STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIIII	DDIG	00	COMPL	ETED
		155697	A. BUII			10/17/	2012
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP CODE		
OL A DICE	SELLA DULITATIONI A	ND OWN LED NUIDOING GENTED			ITTLE LEAGUE BLVD		
CLARK R	KEHABILITATION A	AND SKILLED NURSING CENTER		CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
	This visit was fo	r Investigation of	F00	00	Submission of this plan of		
	Complaints IN00	0117302 and			correction does not constitute	an	
	IN00117175.				admission or agreement by C		
	11100117173.				Rehabilitation and Skilled Nurs	sing	
	C1	117202 G 1 4 4 4 4 1			Facility of the facts alleged of		
	Complaint IN00117302 - Substantiated.				conclusions set forth in this		
		iciencies related to the			statement of deficiencies. The	;	
	allegations are ci	ited at F226, F309, F329,			plan of correction and specific corrective actions are submitted	h.	
	and F465.				and/or executed in compliance		
					with state and federal laws.Thi		
	Complaint IN00	117175 - Substantiated.			plan of correction constitutes of		
	*	iciencies related to the			credible allegation of complian		
					with all regulatory requirement		
		ited at F224, F226, F309,					
	F314, F425, F43	1, F441, F465, and F518.					
	Unrelated deficie	ency cited.					
		, and the second					
	Survey dates: O	ctober 10, 11, 15, 16, and					
	_	ctober 10, 11, 15, 10, and					
	17, 2012						
	Facility number:						
	Provider number	r: 155697					
	AIM number: 1	00266560					
	Survey team:						
	Jennie Bartelt, R	N TC					
	-						
		N (October 10 and 11,					
	2012)						
	Gwen Pumphrey	, RN (October 10 and					
	11, 2012)						
		RN (October 10 and 11,					
	2012)	· · · · · ·					
	2012)						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

000059

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/19/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155697	A. BUILDING B. WING		COMPLETED 10/17/2012	
	PROVIDER OR SUPPLIER	.ND SKILLED NURSING CENTER	517 N L	ADDRESS, CITY, STATE, ZIP CODE LITTLE LEAGUE BLVD SVILLE, IN 47129		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
	Census bed type SNF: 7 SNF/NF: 63 Total: 70	:				
	Census payor ty Medicare: 11 Medicaid: 51 Other: 8 Total: 70	pe:				
	cited in accordar	es reflect state findings nce with 410 IAC 16.2. completed 10/23/12				

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Event ID: 9XMK11

Facility ID: 000059

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPL	ETED
		155697	A. BUIL			10/17/	2012
			B. WING				
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					ITTLE LEAGUE BLVD		
CLARK R	REHABILITATION A	ND SKILLED NURSING CENTER		CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0164 SS=E	OF RECORDS The resident has privacy and confidence personal and clin Personal privacy medical treatmen communications, meetings of family this does not require private room for except as provided this section, the residence private room, the residence private room, the residence private room for except as provided this section, the residence private room for except as provided this section, the residence private room for except as provided this section, the residence private residence private room for except as provided this section, the residence private residen	the right to personal dentiality of his or her ical records. includes accommodations, t, written and telephone personal care, visits, and y and resident groups, but uire the facility to provide a					
	The resident's rig personal and clin when the residen health care instituted by law. The facility must information containecords, regardlemethods, except transfer to another law; third party	dividual outside the facility. th to refuse release of fical records does not apply it is transferred to another ation; or record release is keep confidential all ined in the resident's ss of the form or storage when release is required by the release is required by the release institution; ayment contract; or the					
	the facility failed privacy during conserved during	ation and record review, I to ensure the resident's are for 6 of 10 residents hands-on care in a Residents U, K, A, J, I,	F010	64	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?Privacy curtains, window curtains/blinds, and do closed to ensure privacy is afforded to residents during caresidents covered so as to no be left fully exposed while care	oors are. t	11/16/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 9XMK11

Facility ID: 000059

If continuation sheet

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLETED	
		155697	B. WIN			10/17/2012	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	8			ITTLE LEAGUE BLVD		
CLARK F	REHABII ITATION A	AND SKILLED NURSING CENTER			SVILLE, IN 47129		
			1				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIAT	TE COMPLETION DATE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	· ·		
1					preparations are being made t staff.Residents U, K, A, J, I, ar		
		at 5:10 a.m., CNA #18			O did not have a negative		
was observed providing incontinent care				outcome related to the alleged			
	for Resident U.	Resident U was lying in			deficient practice. How other		
	her bed. CNA #	18 did not pull the curtain			residents having the potentia	al	
	between the bed	s or Resident U and her			to be affected by the same		
	roommate, who	was also lying in bed.			deficient practice will be		
		dcovers were removed,			identified and what corrective	e	
		was left exposed from			action(s) will be taken?All residents have the potential to	ho	
		-			affected by the alleged deficien		
	the waist down as CNA #18 moved away from the bed to locate and work with				practice.Privacy curtains, wind		
					curtains/blinds, and doors clos	• • • • • • • • • • • • • • • • • • •	
		care, and then as the CNA			to ensure privacy is afforded to	• • • • • • • • • • • • • • • • • • •	
	provided the inc	ontinent care.			residents during care. Reside		
					covered so as to not be left ful	-	
	2. On 10/10/12	at 11:25 a.m., LPN #11			exposed while care preparatio		
	was observed co	ompleting a bolus			are being made by staff.Nursir staff in-serviced on privacy/dig		
	gastrostomy tube	e feeding and site care for			by the SDC/designee-post tes		
		sident K was lying in bed			included.Non-compliance with		
		the bed up. The bed			these practices will result in		
		oulled around the			further education including		
	_	g the feeding, the			disciplinary action.DNS/design	nee	
	_	<u> </u>			is responsible to ensure		
		nen was exposed. The			compliance. What measures we be put into place or what	VIII	
		ned exposed during care			systemic changes will be ma	de	
ı	_	ny tube site, and the			to ensure that the deficient	uc	
	resident's right b	oreast was fully exposed.			practice does not		
					recur?Nursing staff in-serviced	d	
	3. On 10/10/10	at 3:05 p.m., CNA #14			on privacy/dignity by the		
	was observed pr	oviding incontinent care			SDC/designee-post test		
	•	The resident's room door			included.Non-compliance with		
		entry was allowed after			these practices will result in further education including		
	· ·	resident was lying in the			disciplinary action.DNS/design	nee	
	_	ed with CNA #14 on the			is responsible to ensure		
ı					compliance. How the corrective	re l	
		ed. The curtain between			action(s) will be maintained t		
	the first and seco	ond beds was not pulled,					

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURV	EY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	,
		155697	A. BUII B. WIN			10/17/2012	2
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹			ITTLE LEAGUE BLVD		
CLARK F	REHABII ITATION A	AND SKILLED NURSING CENTER			SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	MPLETION
IAG		LSC IDENTIFYING INFORMATION)	-	TAG	·		DATE
		was exposed from the			ensure the deficient practice will not recur, i.e., what quali	fr.	
	waist down.				assurance program will be p	-	
	4. On 10/11/12 at 12:10 p.m., LPN #15				into place? CQI tool for		
					privacy/dignity will be utilized		
	was observed du	ring wound care for			weekly x 4, monthly x 6 and		
		resident's door was open			quarterly thereafter during all	3	
		and the bed curtain was			shifts.Findings from the CQI		
	-	d Resident J. LPN #15			process will be reviewed mont	hly	
	_	dent's feet and began to			and an action plan will implemented as needed for ar	,	
	*	e			deficient practice below the 95		
	provide care to the toes. During the care, CNA #16 approached the open door with				threshold.DNS/designeee is		
					responsible to ensure complia	nce	
		indicated, "Knock!					
		ome in?" and entered the					
		indicated she would					
	return with the ti	ray and indicated, "I'll					
	pull this door to.	" The curtain was not					
	pulled around th	e resident's bed as care					
	continued.						
	5. On 10/15/12	at 10:55 a.m., CNAs #12					
		eserved providing					
		for Resident I. Resident					
		ed next to the window					
		curtains open to a view					
		glassed-in smoke shed					
	<u>-</u>	s. The room door was					
	_	curtain between the bed					
		vas partially pulled. A					
	CNA stood on ea	ach side of the bed. As					
	the CNAs reache	ed to remove the					
	resident's bed covers, closing of the door and window curtains was requested and						
		resident's bed covers					
	_	and CNA #12 removed					

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Event ID: 9XMK11

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/19/2012 FORM APPROVED OMB NO. 0938-0391

	OF GODDEGTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPI	
		155697	B. WIN	IG		10/17	/2012
NAME OF F	PROVIDER OR SUPPLIER	₹		1	DDRESS, CITY, STATE, ZIP CODE		
01.45145	SELLA DULLEA ELONI.	ND 01411 ED NUIDON O OENTE	_		ITTLE LEAGUE BLVD		
CLARK	REHABILITATION A	AND SKILLED NURSING CENTE	K	CLARKS	SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	n, leaving the resident					
	1 1 1	osed from head to toe.					
	1	fully exposed while CNA					
		pag for soiled linens,					
		bedside to dispose of the					
		ined cleansing supplies in					
		throom. CNA #12 stood					
		aring this time. The					
		ed completely exposed					
		as incontinent care was					
	1 *	#12 left the bedside,					
	_	eeded to help another					
	resident. While	the resident remained					
	fully exposed, C	NA #14 left the room to					
	obtain linens. W	When care was complete,					
	CNA #14 indica	ted to Resident I, "We'll					
	get a gown and s	sheet on you."					
	6. On 10/16/12	at 1:20 p.m., CNAs #10					
	and #8 were obs	erved providing					
	incontinent care	for Resident O. The					
	resident was trai	nsferred by Hoyer lift					
	from wheel chai	r to bed, and her pants					
	were removed, e	exposing her brief and					
		e CNA #10 searched for					
	_	esident's bedside table and					
	prepared a basin	of water in the bathroom,					
		in bed with brief and bare					
	1	ed. CNA #8 remained at					
		dside during this time.					
	The facility's "S	kills Validation - CNA for					
	1	vas provided by the Nurse					
		0/15/12 at 1:00 p.m.					
	I	*	- 1				1

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Event ID: 9XMK11

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/19/2012 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155697	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 10/17/2012
	PROVIDER OR SUPPLIER REHABILITATION AND SKILLED NURSING CENTER	517 N L	ADDRESS, CITY, STATE, ZIP CODE LITTLE LEAGUE BLVD SVILLE, IN 47129	-
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION
			CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 9XMK11

Facility ID: 000059

If continuation sheet

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION (X3) 1			(X3) DATE S	(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLE	ETED	
		155697	B. WIN			10/17/2	2012	
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE	L		
NAME OF P	ROVIDER OR SUPPLIER	1		l	LITTLE LEAGUE BLVD			
CLARK R	REHABILITATION A	ND SKILLED NURSING CENTER						
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
F0224	483.13(c)							
SS=E	PROHIBIT	5/NJE 01 E 0 T/M/10 A D D D 0 D						
	MISTREATMENT/NEGLECT/MISAPPROP RIATN The facility must develop and implement							
		nd procedures that prohibit						
		glect, and abuse of						
		sappropriation of resident						
	property.							
	Based on record	review and interview, the	F02	24	What corrective action(s) wil	ı	11/16/2012	
	facility failed to	ensure residents were			be accomplished for those			
	protected from n	nisappropriation of			residents found to have beer	1		
	•	and medications for 4 of			affected by the deficient			
	4 residents revie				practice?Employees involved	in		
					the alleged misappropriations were suspended immediately	and		
	misappropriation in a sample of 21. (Residents E, F, H, and M)				terminated after investigation			
	(Residents E, F,	H, and M)			completed.Resident F's money			
					was replaced to his	′		
	Findings include	:			accountResident E's money w			
					replacedResident's H and M w	/ere		
	 During interv 	riew on 10/15/12 at 3:45			not affected by the alleged			
	p.m., Resident F	indicated a facility staff			deficient practice and recieved their medications as	1		
	member had take	en and cashed checks			prescribed. How other			
	from the checkb	ook he kept in a tub on			residents having the potentia	al I		
		e next to his bed. The			to be affected by the same			
		d his name and his			deficient practice will be			
		's name were on his bank			identified and what corrective	е		
		staff member had made			action(s) will be taken?All	.		
	,				residents have the potential to			
		himself and signed the			affected by the alleged deficient practice. An audit of all personal			
		Resident F indicated he			records conducted to ensure a			
	_	dent to the facility, and			required certification/licensure	I		
		right away. The resident			documents and background			
	indicated the bar	nk put stop payment on			checks are present and			
	the checks, and l	nis money had been			accurate.All potential			
	returned to his a	ccount. Resident F			employees requiring			
	indicated the star	ff member would be			certification/license will have proofverification of their			
	prosecuted.				certification/license evidenced	hv		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLE	ETED
		155697	B. WIN			10/17/2	2012
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	1			LITTLE LEAGUE BLVD		
CLARKE	DELIADII ITATIONI A	ND SKILLED NURSING CENTER	5		SVILLE, IN 47129		
CLARK	REHABILITATION A	IND SKILLED NORSING CENTER	`	CLARK	3VILLE, IN 47 129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ĩΕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					a current copy of		
	Review of the fa	cility's file related to			their certificate/license unless		
		en checks indicated the			they are a c.n.a. awaiting testing		
		resident became aware			They then must provide proof of attendance in a c.n.a. class an		
					will not be allowed to work with		
	_	checks missing on 9/4/12			residents until this information		
		otified him his account			provided. Background checks		
	was overdrawn.	The checks appeared to			be completed for all potential		
	be made out to a	person whose name			employees. No one will be		
	matched that of	an employee at the			allowed to work without an		
		ployee was suspended			approved background		
	<u>-</u>	ation, and the police were			check. SDC and front office sta	aff	
		-			in-serviced 1:1 on necessary		
		ated an investigation.			certification/licensure and		
	_	ice report indicated			background checks required for		
	evidence gathere	ed by police included			employee records prior to bein	9	
	video footage of	a former employee who			hired.All staff in-serviced on abuse by the SDC/designee-p	oet	
	worked as a CN	A (CNA #6) at the			test included. Non-compliance		
		eo showed the former			with these practices will result		
		g three checks for the			suspension pending investigat		
		_			and possible termination for ar		
	1	g from Resident F's bank			alleged abuse.SDC and		
		davit for the arrest of			Executive Director/designee a	е	
	CNA #6 had bee	n submitted to the local			responsible to ensure		
	county Prosecuto	or's office.			compliance.What measures w	/ill	
					be put into place or what	_	
	The employee fi	le for CNA #6 was			systemic changes will be ma	de	
		11/12 at 9:55 a.m. The			to ensure that the deficient		
					practice does not recur? All		
		VA #6 was hired on			potential employees requiring certification/license will have		
		ed lacked documentation			proof/verification of their		
	of CNA #6's cert	tification or Nurse Aide			certification/licensure evidence	ed l	
	Training in prepare	aration for certification			by a current copy of		
	testing.				their certificate/license unless		
					they are a c.n.a. awaiting testing	ng.	
	During interview	on 10/11/12 at 2:45			They then must provide proof	of	
	~	y on 10/11/12 at 3:45			attendance in a c.n.a. class an		
		or of Nursing Services			will not be allowed to work with		
	(DNS) indicated	the facility had realized			residents until this information	is	

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Event ID: 9XMK11

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLE	ETED
		155697	B. WIN			10/17/2	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	8			ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	AND SKILLED NURSING CENTER			SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		nt that not all employee			provided. Background checks	will	
	files included ap	propriate screening of			be completed for all potential employees. No one will be		
	potential employees, including CNA certification. She indicated CNA #6 had				allowed to work without an		
					approved background check.		
	not been checked	d for certification prior to			SDC and front office staff		
		he indicated she had just			in-serviced 1:1 on necessary		
		Aide Trainer who told her			certification/licensure and		
	-	ve training, but did not			background checks required for		
		•			employee records prior to bein hired.All staff in-serviced on	ig	
	show up for his	iest.			abuse by the SDC/designee-p	ost	
					test included. Non-compliance		
	Review of the facility's policy for Abuse				with these practices will result		
		orting, and Investigation,			suspension pending investigat	tion	
	included in the f	ile related to the			and possible termination for ar	ny	
	misappropriation	n of Resident F's money,			alleged abuse.SDC and		
	indicated, "1.An	nerican Senior			Executive Director/designee a responsible to ensure	re	
	· ·	ill not permit residents to			compliance. How the corrective	<i>γ</i> Δ	
		abuse by anyone 2.			action(s) will be maintained t		
		reening is done on all			ensure the deficient practice		
		yees to assure that the			will not recur, i.e., what quali		
		employ individualsb.			assurance program will be p	ut	
	_	e current licensure or			into place?CQI audit tool for		
					employee records will be utilize		
	certification clea	_			for all new hiresCQI audit tool		
	Ū	sappropriation of resident			abuse will be utilized weekly xand monthly x6 and quarterly	4	
	property"				thereafter. Findings from the C	qı	
					process will be reviewed mont		
	2. During interv	riew on 10/15/12 at 10:00			and an action implemented as		
	a.m., Resident E	indicated she had three			needed for any deficient practi	ice	
	\$1.00 bills and a	\$20.00 gift card stolen			below the 95%		
		She indicated she			threshold. Executive Director/designee is responsib	ا مار	
	_	the facility took action			to ensure compliance with	,,,,,	
					employee records.DNS and		
	right away. She indicated she didn't know who the thief was, but she understood it				Executive Director/Designee a		
		<i>'</i>			responsible to ensure complia	nce	
	_	on caught on camera			with abuse policy.		
	spending the car	d. She indicated the					

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If continuation sheet

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIT	I DINC	00	COMPI	LETED
		155697		LDING		10/17	/2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			ITTLE LEAGUE BLVD		
		AND SKILLED NURSING CENTE	D		SVILLE, IN 47129		
	LIADILITATION F	AND SKILLED NORSING CENTE	.rx	CLARK	OVILLE, IN 41 129		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	money and card	had been replaced.					
	Review of the fa	acility's file related to					
		len card and money					
		lowing: On 8/29/12, the					
		aware and reported the					
		•					
	_	and three \$1.00 bills					
		r purse in the chest of					
		oom. An attached typed					
	document, signe	ed by the former Executive					
	Director indicated the following:						
	Resident E was	interviewed related to the					
	reported missing	g items, and the police					
		d investigated. Residents					
		resident's hall were					
		ted to misappropriation,					
		ices followed up with the					
	resident.						
	3. Review of an						
	Department of H	Health Incident Report					
	Form related to	Residents H and M					
	indicated on 9/1	7/12, a nurse (LPN #9)					
		edications noticed the					
		edication packaging had					
		with, and narcotic					
	_						
		Residents H and M had					
	_	side their bubble packs					
	with different m	edications.					
	A. The initial r	eporting documentation					
	related to the me	edications was					
		plain paper and signed by					
		port indicated "Monday					

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155697	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/17/2012
NAME OF P	ROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE	
				ITTLE LEAGUE BLVD	
		ND SKILLED NURSING CENTER		SVILLE, IN 47129	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI	
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	
	9/17/12 @ 4 PM	, this writer was pulling			
	meds [medicatio	ns] - was getting [name			
	_	meds ready. I pulled her			
		e front card, then counted			
	-	pulling cards apart (they			
		led) I noticed the 3rd card			
		tion looking different			
		turned card over & it had			
	•	enterThis writer then			
	looked at narc [narcotic] sheets				
	corresponding [with] the tampered meds I				
	-	dent H's] sheet on			
	_ ·	count was 170 per this f. Following date (next			
		1. Following date (next 1 a.m. count was 152"			
	uose) 9/11/12 (0)	1 a.m. Count was 132			
	B. The same ini	tial reporting			
		lso indicated the narcotic			
		Resident M's narcotics			
	had been tamper				
	•	indicated, "Also on			
	[Resident M's] sl	heet on same dates			
	9/10/12 @ 9 pm	count was 169. Then			
	next dose 9/11/1	2 @ 1 am count was			
	151."				
	Trl Cil. : 1:	11 DN 1/7 1 DN 1/7 1			
		d LPN #7, LPN #5, and			
		spended, the police were			
		stigation, and the nurses			
		ly terminated. Residents			
		for negative effects of the received inservice			
	education.	TOCCIVEU HISELVICE			
	caucanon.				
			1		

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155697	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE COMPI 10/17	ETED
	REHABILITATION A	ND SKILLED NURSING CENTER	517 N L	ADDRESS, CITY, STATE, ZIP CODE ITTLE LEAGUE BLVD SVILLE, IN 47129		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	O BE	(X5) COMPLETION DATE
	This federal tag IN00117175.	is related to Complaint				
	3.1-28(a)					

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLI	ETED
		155697	B. WIN			10/17/	2012
NAME OF B	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER			517 N L	LITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	AND SKILLED NURSING CENTER		CLARK	(SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION
TAG F0226		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
SS=E	483.13(c) DEVELOP/IMPLI ETC POLICIES	MENT ABUSE/NEGLECT,					
		develop and implement					
		nd procedures that prohibit					
		glect, and abuse of sappropriation of resident					
	property.	suppropriation of rediaent					
		review and interview, the	F02	26	What corrective action(s) wil	ıı İ	11/16/2012
	facility failed to	ensure implementation of			be accomplished for those		
	its abuse prevent	-			residents found to have been	n	
	•	screening for licensure			affected by the deficient		
		clear of findings for 4 of			practice?Resident F's money was replaced to his account, t		
		ose files were reviewed			employee involved with		
		d certification. (CNA #6,			the alleged deficient practice v		
		‡2, and LPN #7) The			suspended pending investigat		
	•	e affected 1 of 4 residents			and ultimaately terminated. No other residents were affected		
	•	to misappropriation in a			the alleged deficient practice I	-	
		idents. (Resident F)			other residents having the		
	r	, ,			potential to be affected by the		
	Findings include	2:			same deficient practice will I		
		•			identified and what corrective	e	
	1 Review of the	e facility's policy for			action(s) will be taken?All residents have the potential to	n he	
		on, Reporting, and			affected by the alleged	, 50	
	Investigation, pr				deficient practice.All potential		
		n 10/10/12 at 7:20 a.m.,			employees requiring a		
	indicated, "1. Ar				certification/license will have proof/verification of their		
	· ·	ill not permit residents to			certification/license evidenced	l bv	
		abuse by anyone 2.			a current copy of	,	
	_	reening is done on all			their certificate/license unless		
		yees to assure that the			they are a c.n.a. awaiting testing. They then must provide	10	
		employ individualsb.			proof of attendance in a c.n.a.		
		e current licensure or			class and will not be allowed t		
	certification clea				work with residents until this		
		sappropriation of resident			information is	الثمد	
	concerningiiii	sappropriation of resident			provided. Background checks be completed for all potential	vVIII	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155697	B. WING			10/17/	2012
		1		_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	8			ITTLE LEAGUE BLVD		
		AND SKILLED NURSING CENTER		CLARK	SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	property"				employees. No one will be allowed to work without an		
					acceptable background		
	Employee files v	were reviewed on			check. SDC and Front office s	taff	
	10/11/12 at 9:55	a.m.			in-serviced 1:1 on necessary		
					certification/licensure and		
	A The file for	CNA #6 indicated a hire			background checks for employ		
		The filed lacked			records prior to being hired.All		
		of CNA #6's certification			staff in-serviced on abuse by t	he	
					SDC/designee-post test included. Non-compliance with	,	
		raining in preparation for			these practices will result in	ı	
	certification test	ing.			suspension pending investigat	ion	
					and possible termination for a		
	During interviev	v on 10/11/12 at 3:45			alleged abuse.SDC and	,	
	p.m., the Directo	or of Nursing Services			Executive Director/designee a	re	
	(DNS) indicated	the facility had realized			responsible to ensure		
	recently not all e	employee files included			compliance. What measures	Will	
	1	ening of potential			be put into place or what	da	
		uding CNA certification.			systemic changes will be ma to ensure that the deficient	ue	
		NA #6 had not been			practice does not recur? All		
					potential employees requiring	а	
	checked for cert	_			certification/license will have		
		he indicated she had just			proof/verification of their		
	•	Aide Trainer who told her			certification/license evidenced	by	
		ve training, but did not			a current copy of their		
	show up for his	certification test."			certificate/license unless they a c.n.a. awaiting testing.	are	
					They then must provide proof	of	
	B. The file for 0	CNA #4 indicated a hire			attendance in a c.n.a. class ar		
	date of 7/30/12.	Documentation in the			will not be allowed to work with		
	file indicated CN	NA #4's certification was			residents until this information	_	
	checked on 9/12				provided. Background checks	will	
	onconed on 7/12	, 			be completed for all potential		
	C The file for C	CNA #2 indicated a hire			employees. No one will be allowed to work without an		
					acceptable background		
		Documentation in the	check.SDC and Front office staff			aff	
	file indicated CNA #2's certification was				in-serviced 1:1 on necessary		
	checked on 9/12	/12.			certification/licensure and		
					background checks for employ	/ee	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPLE	TED
		155697	A. BUILI B. WING			10/17/2	2012
			J. WINO		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	t			ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	AND SKILLED NURSING CENTER			SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		LPN #7 indicated a hire			records prior to being hired. A		
	date of 7/31/12. Documentation in the				staff were in-serviced on abus by the SDC/designee on (date		
	filed indicated L	PN #7's license was			post test	,	
	checked on 9/26	/12.			included. Non-compliance with	n	
					these practices will result in		
	During interview	v on 10/15/12 at 3:45			suspension pending investigat		
	_	indicated a facility staff			and possible termination for a	ny	
		en and cashed checks			alleged abuse.SDC and Executive Director/designee a	re	
		ook he kept in a tub on			responsible to ensure	16	
		e next to his bed. The			compliance. How the corrective	ve	
		d his name and his			action(s) will be maintained t		
					ensure the deficient practice		
		's name were on his bank			will not recur, i.e., what quali	ty	
		staff member had made			assurance program will be p	ut	
	the checks out to	himself and signed the			into place?CQI audit tool for		
	mother's name.	Resident F indicated he			employee records will be utiliz	ed	
	reported the inci	dent to the facility, and			for all new hires.CQI tool for abuse will be utilized weekly x	4	
	action was taken	right away. The resident			monthly x6 and quarterly	·,	
	indicated the bar	nk put stop payment on			thereafter.Findings from the C	QI	
		his money had been			process will be reviewed mont	thly	
	· ·	ccount. Resident F			and an action plan		
		ff member would be			implemented as needed for ar	,	
	prosecuted.	ii iiidiiddi wddid de			deficient practices below the 9 threshold.Executive	13%	
	prosecuted.				Director/designee is responsib	ole	
	Davious of the fa	aility's file related to			to ensure compliance with		
		cility's file related to			employee records.DNS and		
		en checks indicated the			Executive Director/designees		
	_	resident became aware			responsible to ensure complia	nce	
	_	checks missing on 9/4/12			with abuse policy.		
		otified him his account					
	was overdrawn.	The checks appeared to					
	be made out to a	person whose name					
	matched that of an employee at the						
		ployee was suspended					
		ation, and the police were					
		ated an investigation.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/19/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER: 155697	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPLETED 10/17/2012
	PROVIDER OR SUPPLIER REHABILITATION AND SKILLED NURSING CENTER	517 N L	ADDRESS, CITY, STATE, ZIP CODE LITTLE LEAGUE BLVD (SVILLE, IN 47129	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	The attached police report indicated evidence gathered by police included video footage of a former employee who worked as a CNA (CNA #6) at the facility. The video showed the former employee cashing three checks for the amounts missing from Resident F's bank account. An affidavit for the arrest of CNA #6 had been submitted to the local county Prosecutor's office. This federal tag is related to Complaint IN00117175 and Complaint IN00117302. 3.1-28(a)			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLI	ETED
		155697	B. WIN			10/17/	2012
	ROVIDER OR SUPPLIER	ND SKILLED NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	MANUFERS N. AN OF CONDUCTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE .	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	16	DATE
F0309 SS=E	HIGHEST WELL Each resident mu must provide the services to attain practicable physic psychosocial wel the comprehensic care. A. Based on rec the facility failed	ust receive and the facility necessary care and or maintain the highest	F03	09	What corrective action(s) will be accomplished for those residents found to have beer		11/16/2012
	provided as ordereviewed related 21. (Resident Q B. Based on obserview, the facility resident with a more received wound for 1 of 2 resident non-pressure wo (Resident B) C. Based on observed residents complaints complaints complaints assessment, care to relieve the pair reviewed related 21. (Residents F.)	ered for 1 of 1 resident to angina in a sample of to angina in a sample of the angina in a sample of the arrangements are to promote healing and the reviewed related to a bound in a sample of 21. Servation, interview, and the facility failed to ensure and an efacility failed to ensure an efacility failed to en			affected by the deficient practice? Resident Q did not have a negative outcome relat to the alleged deficient practic and meds are documented gives as prescribed. Resident B's wound to the right heel is resolved. Residents H is recieved pain medication as prescribed and as needed. Residents I is recieving pain medications as prescribed and is effective. Resident O pain was assessed and a prn pain medication was ordered. How other residents having the potential to be affected by the same deficient practice will be identified and what correctives action(s) will be taken? All residents have the potential to affected by the alleged deficied practices. Licensed nurses in-serviced on assessing pain, change of condition,	e ven ving e e e e h be nt	
	Findings include A. The clinical	e: record for Resident Q was			reporting, following MD orders and providing care by the SDC-post test included.All new orders are reviewed daily as w	N	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLE	TED
		155697	B. WIN			10/17/2	.012
			b. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER	!		SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		DATE
	reviewed on 10/1	10/12 at 9:30 a.m. The			as report sheets by the IDT/Ur	nit	
	record indicated	the resident's diagnoses			Managers to determine if a		
		re not limited to, angina			change of condition and/or		
	pectoris.	To not mintou to, ungmu			change in a residents comfort	has	
	pectoris.				occured. Findings from this review will be further reviewed	ا ما	
	D1	6 6 4 1 2012			- documentation, MD/family	1.6.	
	_	rs for September 2012			notification, pain assessments	.	
	included, but we	,			orders obtained and plan of ca		
	"Nitrostat 0.4 mg	g sub [sublingual], Take 1			updated.Non-compliance with		
	tablet sublingual	ly every 5 mins [minutes]			these practices will result in		
	X3 doses as need	ded for chest pain. If no			further education including		
	relief, call MD."	-			disciplinary action.DNS/design	ee	
	, , , , , ,				is responsible to ensure	.:u	
	The Core Plan d	lated 5.25/11 with Giak			compliance.What measures w be put into place or what	/III	
	1				systemic changes will be ma	de	
	· ·	, for "At risk for chest			to ensure that the deficient	ue	
		to] Dx [diagnosis] of			practice does not		
	angina, CAD [co	oronary artery disease,			recur? Licensed nurses		
	hyperlipidemia a	and pericarditis" included,			in-serviced on assessing		
	but was not limit	ted to the following			pain, change of condition,		
	Approach, "Med	s [medication] as			reporting, following MD orders		
	ordered."				and providing care by the SDC		
					(date), post test included. All n		
	A Progress Note	for nursing, dated for			orders are reviewed daily as w as report sheets by the IDT/Ur		
	_	_			Managers to determine if a	"`	
	9/29/12 at 11:14	•			change of condition and/or		
	-	ained of pain in her			change in a residents comfort	has	
		nd left shoulder blade.			occured. Findings from this		
	_	ined of nausea. She was			review will be further reviewed	i.e.	
	given nitro at 9:4	10 p.m. but pain was not			- documentation, MD/family		
	relieved. Medica	al doctor was contact			notification, pain assessments orders obtained and plan of ca		
	[sic] but was not	reached. [Name of			updated.Non-compliance with		
		er] was called and was			these practices will result in		
	_	lent out. Resident was			further education including		
		s of O2 [oxygen] for			disciplinary action.DNS/design	ee	
	_				is responsible to ensure		
		nt threw up once but			compliance. How the corrective		
	nausea wasn't rel	lieved."	1		action(s) will be maintained to	o l	

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Facility ID: 000059

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріш	DING	00	COMPLI	ETED
		155697	A. BUII			10/17/	2012
			B. WIN		DDDEGG CITY CTATE ZID CODE		
NAME OF P	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP CODE		
OLADIC E		NID OKU LED NUIDOINO OFNITED			ITTLE LEAGUE BLVD		
CLARK F	KEHABILITATION A	ND SKILLED NURSING CENTER		CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					ensure the deficient practice		
	The Medication	Administration Record			will not recur, i.e., what quali	ty	
		Nitroglycerin was			assurance program will be p	ut	
					into place?CQI audit for chan		
	administered on	9/29/12.			of condition and pain assessm		
					will be utilized weekly x4, mon	thly	
	The Vital Signs	Record indicated vital			x6 and quarterly	_	
	signs including t	emperature, pulse,			thereafter. Findings from the Coprocess will be reviewed mont		
	respirations, blo	od pressure, and oxygen			and an action plan will e	ıııy	
		neasured on 9/29/12 at			implemented as needed for an	_{IV}	
		: 11:13 p.m. but at no			deficient prctices below the 95		
		11.13 p.m. out at no			threshold. DNS/designee is		
	other times.				responsible to ensure complia	nce	
	The Resident Tra	ansfer Form, dated					
	9/29/12 at 11:08	p.m., indicated the					
	resident was tran	sferred to the hospital at					
	11:10 p.m. on 9/	•					
	11.10 p.m. on 57	27/12.					
	0 10/17/10 + 3	100 41 D: 4 C					
		2:00 p.m., the Director of					
	_	s (DNS) was interviewed					
	related to the adı	ministration of one					
	instead of three 1	Nitroglycerin and the					
	resident's vital si	gns at the time the chest					
		d. At this time, the DNS					
		rse had entered a revised					
	Progress Note in						
		ystem, which included					
	more information	n, and provided the					
	following:						
	-						
	A Progress Note	for nursing, dated for					
	_	o.m., with a note in the					
		l indicating "Edited by					
	_	on 10/17/2012 at 12:31					
	p.m. Reason: Inc	correct data," indicated,					

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Event ID: 9XMK11

Facility ID: 000059

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	MULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	ILDING	00	COMPL	
		155697	B. WIN	NG		10/17/	2012
NAME OF F	PROVIDER OR SUPPLIER		_		ADDRESS, CITY, STATE, ZIP CODE	_	
					ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTE	R	CLARK	SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ained of pain in her					
	l ' '	nd left shoulder blade.					
	_	ined of nausea. She was					
	_	at 9:40 p.m. but pain was					
		edical doctor was contact					
		reached. At that time					
	-	Practitioner] was called					
	_	two baby aspirins and to					
	send resident out	t the [name of local					
	hospital]. Reside	ent was placed on 2 liters					
	of O2 [oxygen] f	for comfort. Resident					
	threw up once af	terwards nausea was					
	relieved."						
	When interviewe	ed related to vital signs					
	when the residen	nt complained of chest					
	pain and the phy	sician's order for the two					
	1 ^ ^ *	ne DNS did not respond.					
		•					
	B. On 10/11/12	at 2:10 p.m., RN #21 was					
		ing wound care for					
	_	nurse removed a gauze					
		ng to the left heel. She					
	_	l with normal saline,					
		in to the entire heel area,					
		el, and initialed and dated					
	the dressing. W	· ·					
		eel area was observed as					
	ĺ	he resident's foot/leg. No					
	open areas were	-					
	open areas were	ouserveu.					
	On 10/16/12 at 4:40 p.m., Resident H was						
		g the dining room in his					
		s right foot was in a boot					

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Event ID: 9XMK11

Facility ID: 000059

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPL	ETED
		155697	A. BUII B. WIN	LDING		10/17/	/2012
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	₹			ITTLE LEAGUE BLVD		
CLADKE		AND SKILLED NURSING CENTER)		SVILLE, IN 47129		
CLARK	REHABILITATION	AND SKILLED NORSING CENTER	`	CLARK	SVILLE, IN 47 129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	apparatus.						
	The clinical reco	ord for Resident B was					
	reviewed on 10.	/15/12 at 12:50 p.m.					
		12.12 w 12.00 p					
	A Non proggura	Wound Skin Evaluation					
		0/10/12, indicated the					
		iabetic ulcer to the right					
	_	0.4 cm X 0.3 cm X 0.1 cm					
	with a red woun	d color.					
	Physician's orde	rs for October 2012					
	included, but we	ere not limited to, an order					
	originally receiv						
		2 500/gm oin [ointment],					
	_	el with normal saline pat					
		acin cover with dry					
		aily and as needed for					
	soilage or dislod	lgement." Orders related					
	to wound care or	n the left heel were					
	lacking.						
	The Treatment A	Administration Record for					
		dicated RN #21's initials					
	`	day shift) entry for					
		2 500/gm oin [ointment],					
	_	el with normal saline pat					
	dry apply Bacitr	acin cover with dry					
	dressing twice d	aily and as needed for					
	soilage or dislod	lgement."					
		-					
	C 1 During In	nitial Tour on 10/10/12 at					
		dent H's room was					
	· ·						
	enterea. The res	sident was observed in	1				I

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Event ID: 9XMK11

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155697	B. WIN			10/17/	2012
NAME OF D	PROVIDER OR SUPPLIEI		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIED	X		517 N L	ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	AND SKILLED NURSING CENTER	1	CLARK	SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	1	TAG	DEFICIENCY)		DATE
		nts were on. The resident					
		vard the bottom of the bed,					
		the bed was rolled up, so					
		ad was cocked up at the					
		ent indicated she was					
	I -	l" from the "top of her					
		r toes." She asked, "May					
		pain pill," and she					
	_	repositioned toward the					
	top of the bed.	The resident indicated she					
	had been asking	for a pain pill since 3:00					
	a.m. She indica	ted she should be able to					
	get her pill an ho	our before to an hour after					
	the scheduled do	ose. She indicated it was					
	"always that wa	y" that staff were not in a					
	hurry to adminis	ster her pain medications.					
	At this time, CN	IA #4 entered the room to					
		nt with repositioning. She					
		as waiting for another aide					
		care. LPN #19 entered					
	Resident H's roo						
	repositioning. F	From the hallway,					
		heard asking, "Where's					
		LPN #19 sighed heavily,					
	"Huh!"	,					
	On 10/10/12 at 4	4:30, LPN #19 was					
		egard to Resident H's pain					
		indicated, "We gotta be					
		related to administration					
	_	ons. He indicated					
	_	ived Percocet every four					
ı		and "It's due at 5 o'clock."					
	_	e also has a Fentanyl patch					
	The mulcaled SH	aiso nas a i cinanyi paten	1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITE	LDING	00	COMPL	ETED
		155697	B. WIN			10/17/	/2012
		<u> </u>	D. 1111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹			ITTLE LEAGUE BLVD		
CLARK F		AND SKILLED NURSING CENTER	₹		SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		n management. He					
	· · · · · · · · · · · · · · · · · · ·	s adamant about her					
	medications."						
	The clinical record fro Resident H was						
	reviewed on 10/	15/12 at 1:30 p.m. The					
	resident's diagno	oses included, but were					
	not limited to, cl	hronic pain.					
	The Nursing Qu	arterly Assessment, dated					
	9/17/12, indicate	ed the resident reported					
	she had had pair	or hurting during the last					
	five days, in her						
	1	ch was moderate,					
		aching, and throbbing,					
		reased with medications					
	and rest.	reased with medications					
	and rest.						
	The Care Plan, o	lated 7/16/12, indicated,					
		in related to decrease					
	_	nd leg pain, chronic pain,					
	1	' Approaches included,					
	_	ited to, "Administer meds					
	[medications] as	· ·					
	[medications] as	ordered.					
	Physician's orde	rs for October 2012					
	*	ere not limited to,					
		daily and as needed for					
		Percocet for narcotic pain					
	_	our hours routine, Fentanyl					
	1	nours for narcotic pain					
	1 ^	three times daily for					
	· ·	· ·					
	1 -	ol 650 mg every six hours					
	as needed for pa	ın.	1				I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155697	B. WIN			10/17/	2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CLARKE	REHARII ITATIONI A	ND SKILLED NURSING CENTER	2		ITTLE LEAGUE BLVD SVILLE, IN 47129		
			`		OVILLE, IIN 77 123	1	(VE)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	The Medication	Administration Record					
	failed to indicate	the Tylenol was					
	administered wh						
	complained of pa	ain on 10/10/12.					
	- ^						
	Resident Progres	ss Notes for nursing					
	included no entri	ies related to pain					
	assessment or ma	anagement on 10/10/12.					
	2. On 10/15/12 a	at 10:55 a.m., Resident I					
	was observed red	ceiving incontinent care					
	provided by CNA	A #14. The resident was					
	lying on a low ai	r loss mattress and had a					
	dressing on the c	coccyx. The CNA rolled					
	the soiled bed pa	d and four-layer draw					
	sheet and the cle	an bed pad and four-layer					
	draw sheet, and a	rolled the resident over					
	the linens to repl	ace soiled linen with					
	clean. As she wa	as rolled over the rolled					
	· ·	ent indicated, "It hurts my					
		o roll over that." The					
	•	place a wedge pillow for					
	1	the resident complained					
		when the wedge was					
	_	nterview at this time, the					
	resident indicated	d she does not hurt for					
	awhile after she	takes her pain pill. She					
	-	n medication is routine,					
		hink she gets pain					
	medication in be	tween routine doses. She					
	indicated she is h	nurting before the next					
	medication is du	e, and then she has to					
	wait for it to relie	eve the pain.					

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Event ID: 9XMK11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIIII	LDING	00	COMPI	LETED
		155697	B. WIN			10/17	/2012
	n oxympun a	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	t .			ITTLE LEAGUE BLVD		
		AND SKILLED NURSING CENTER	₹	CLARK	SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	red 1: : 1	10 D 11 / I					
	The clinical record for Resident I was reviewed on 10/15/12 at 12:45 p.m.						
	The Care Plan, dated 4/25/12, indicated, "Resident has pain related to decreased						
		4 pressure wound, history					
		idium difficile - organism					
	_]." The Goal, with target					
	_	· ·					
		indicated, "Will have					
	•	thin 30 to 60 minutes of					
		approaches included, but					
		to, "Administer meds					
		ordered" and "Notify					
	MD if pain is un	relieved or worsening."					
	Physician's orde	rs for October 2012					
	included, but we	ere not limited to, an order					
	originally receiv						
		min 10-325 mg tab					
	_	edication], take 1 tablet					
	_	four hours." No as					
		lications were prescribed.					
	3. On 10/10/12	at 2:05 p.m., Resident O					
		her wheel chair at the					
		#20 and 22 prepared to					
		lent to bed using the					
		resident was leaning to					
		left arm and hand were					
	· ·	ose to the body. Her feet					
	-	the foot pedals. As the					
	_	connected to the lift, the					
	_						
	resident indicate	d, "Don't hurt my	1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155697			LDING	00	COMPL	
		155697	B. WIN	IG		10/17/	2012
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF	ROVIDER OR SULLEIE				ITTLE LEAGUE BLVD		
		AND SKILLED NURSING CENTE	₹	CLARK	SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DLI ICILIACT)		DATE I
		e hurting my shoulder.					
	1	As the Hoyer lifted the					
		icated, "You're hurting					
		hurting my head." When					
		whether the resident					
		ned of hurting during					
	transfers, the CN	NAs nodded yes.					
	On 10/16/12 at 1	1:20 p.m., CNAs #10 and					
		ed transferring Resident O					
		m wheel chair to bed. As					
	· ·	lifted into bed, she					
		er feet hurting and					
	•	my feet." CNA #10					
	_	sident's feet and indicated					
	-	resident had bunions that					
	_	provided care, CNA #10					
		nks the resident's whole					
		As the resident's stiff					
	=	ated for cleansing of the					
		implained that her legs					
	-	ent complained of hurting					
		d from side to side.					
	us she was rone	a from side to side.					
	The clinical reco	ord for Resident O was					
	reviewed on 10/	11/12 at 10:00 a.m.					
	The Care Plan, o	dated 11/25/11, indicated,					
	"At risk for pain	related to impaired					
	mobility, history	of CVA [cardiovascular					
		eft sided hemiparesis,					
	_	Approaches included, but					
		to, "Administer meds					
	[medications] as	-					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/19/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155697	LDING	00	COMPL 10/17/	ETED
	PROVIDER OR SUPPLIER	.ND SKILLED NURSING CENTER	517 N L	DDRESS, CITY, STATE, ZIP CODE ITTLE LEAGUE BLVD SVILLE, IN 47129		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	indicated the rest order for pain months of the pain months of the physician/Prescriber recommended disphysician's order to non-use during The resident's physician on the physician's order to non-use during the resident's physician's physician's physician's order to non-use during the resident's physician's physician	ote to Attending liber," dated 7/25/12, scontinuation of the for Acetaminophen due g the preceding 150 days. hysician signed in				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLI	ETED
		155697	B. WIN			10/17/	2012
					ADDRESS, CITY, STATE, ZIP CODE	L	
NAME OF P	ROVIDER OR SUPPLIER	L		l	ITTLE LEAGUE BLVD		
CLARK R	REHABILITATION A	ND SKILLED NURSING CENTER		CLARK	SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
F0314 SS=D	483.25(c) TREATMENT/SV PRESSURE SOF Based on the con a resident, the fact resident who enter pressure sores do sores unless the condition demons unavoidable; and sores receives not services to promot infection and previous developing. Based on observer record review, the pressure wounds planned, treatme manufacturer's in for promotion of wounds for 3 of related to pressur 21. (Residents I. Findings include 1. On 10/15/12 and #14 were ob incontinent care I was lying in be with SenTech on the mattress. Du draw sheet folde observed under to During interview indicated when to	CS TO PREVENT/HEAL RES Inprehensive assessment of cility must ensure that a gers the facility without the poes not develop pressure individual's clinical strates that they were a resident having pressure excessary treatment and tote healing, prevent event new sores from ation, interview, and the facility failed to ensure a were assessed and care ents were in place, and instructions were followed a residents reviewed the wounds in a sample of the pressure of	F03		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident I now using only 1 flat regular draw sheet of the low air loss mattress bed pranufacturers instructions. Resident K's skin report, and care plan reflect the same pressure area, and dressing is in place as ordered. The c.n.a.'s report to the nurse immediately if the dressing has come off. Resident S has pass away How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficient practice. Licensed nurses in-serviced on asssessing residents skin upon admission and weekly by the wound nurse/designee. In-service alse	on per e d. e s sed di l	11/16/2012

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155697	A. BUII B. WIN			10/17/	2012
		l .	D. WIN		ADDRESS, CITY, STATE, ZIP CODE	I	
NAME OF P	PROVIDER OR SUPPLIEF	t			LITTLE LEAGUE BLVD		
CLARK F	PEHARII ITATION A	AND SKILLED NURSING CENTER			SVILLE, IN 47129		
			•				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	·		DATE
		sed under the resident, but			given on the use of specialty mattresses per manufacturer		
	when the resider	nt has large or loose			instructions-post test included	ΔΙΙ	
	bowel movemen	ts, two underpads and the			new admissions and	. All	
	draw sheet are u	sed.			re-admissions will have their s	kin	
					assessed by the admitting cha		
	The clinical reco	ord for Resident I was			nurse/unit manager for any		
	The clinical record for Resident I was reviewed on 10/15/12 at 12:45 p.m. The				alterations in skin integrity.		
		the resident was admitted			Weekly skin assessments will		
					completed by the charge nurs		
		tage 4 pressure wound to			for all residents as scheduled. wounds identified on admission	•	
	the coccyx.				on the weekly skin	11 01	
					assessment will be measured		
	The Care Plan, v	with start date of 7/16/12,			MD notified, treatment obtained		
	indicated, "Skin:	Resident has impaired			indivdual wound sheet comple		
	skin integrity: P	-			and care planned by charge		
		yx." Approaches			nurse/unit manager. The wou		
	·	ere not limited to, "Low			nurse will then assess findings		
	-				ensure treatment in place and		
	air loss mattress.	.''			appropriate documentation completed. Non-compliance w	<i>i</i> ith	
					these practices will result in	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
		ound Skin Evaluation			further education including		
	Report, dated 10	0/15/12, indicated the			disciplinary action.Wound		
	resident's wound	I was Stage 4, 6.1 X 8.6			nurse/designee is responsible	to	
	X 1.0 cm with u	ndermining in two areas.			ensure compliance.What		
					measures will be put into pla		
	 Manufacturer's i	nstructions from the			or what systemic changes w	ill	
		ing the Sentech Stage IV			be made to ensure that the		
		air loss mattress for			deficient practice does not recur? Licensed nurses were		
					in-serviced on asssessing		
		provided by the Medical			residents skin upon admission	1	
		r on 10/17/12 at 2:15 p.m.			and weekly on (date) by the		
	The instructions	s indicated, "In order to			wound nurse/designee. Inser	vice	
	reduce the physi	cal factors that cause			also given on the use of speci	alty	
	pressure ulcers	recommends the			mattresses per manufacturer		
	•	of bed linens with all of			instructions. Post test		
		pecifically indicated for			included. All new admissions		
		ge IV 2000/3000 were			re-admissions will have their s		
	i me sen rech sta	ge iv Zuuu/Juuu wele	1		assessed by the admitting cha	ııy c	I

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF			URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLE	TED
		155697	B. WIN			10/17/2	2012
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	I.R			LITTLE LEAGUE BLVD		
CLARK F	REHABILITATION	AND SKILLED NURSING CENTER	₹		SVILLE, IN 47129		
			` _		1		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	``	NCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	+	R LSC IDENTIFYING INFORMATION)		TAG	·	1	DATE
		ems: "One flat regular			nurse/unit manager for any alterations in skin integrity.		
	turn sheet; One disposable chux"				Weekly skin assessments will	he	
					completed by the charge nurse		
	2. On 10/10/12	at 2:50 p.m., LPN #11			on all residents as scheduled.		
	was observed co	ompleting wound care for			wounds identified on admissio	n or	
		iring interview as the			on the weekly skin		
		to provide care, she			assessment will be measured,		
		occyx wound dressing is			MD notified, treatment obtaine		
		-			indivdual wound sheet comple and care planned by charge	eted	
		three days. She indicated			nurse/unit manager. The wou	nd	
		nse the wound with normal			nurse will then assess findings		
		and apply DuoDerm. The			ensure treatment in place and		
	resident was rol	lled to her left side and the			appropriate documentation		
	area was expose	ed. The wound was			completed. DNS/designee will		
	observed to hav	re no dressing, and the			make rounds on all 3 shifts to		
	nurse indicated	it probably came off			ensure specialty mattress are		
		When interviewed			being used per manufacturer instructions. Non-compliance	with	
		de's having notified her			these practices will result in	VVICII	
		d come off and needed to			further education including		
	_				disciplinary action.The wound		
	-	nurse indicated, "[Name			nurse and DNS/designee is		
	of CNA #24] di	dn't mention it."			responsible to ensure		
					compliance. How the corrective		
	The clinical rec	ord for Resident K was			action(s) will be maintained t		
	reviewed on 10	/15/12 at 1:55 p.m.			ensure the deficient practice will not recur, i.e., what quali	1	
					assurance program will be p	-	
	The Care Plan,	dated 7/19/12, indicated,			into place? CQI audit tool for		
	"Resident has in	npaired skin integrity:			skin management will be utilize	ed	
		e wound coccyx."			weekly x 4, monthly x 6 and		
	• •	luded, but were not			quaterly thereafter.CQI audit to		
	* *	atment as ordered."			for specialty beds will be utilize	ed	
	minica to, 11e	annent as ordered.			weekly x4, monthly x6 and	,	
					quarterly thereafter during all 3 shifts. Findings from the CQI)	
		rder, received 10/4/12,			process will be reviewed mont	hly	
	· ·	anse area to coccyx			and an action plan will be	,	
	[symbol for wit	h] NS [normal saline], pat			implemented as needed for ar	ny	
	dry & apply due	oderm to O/A [open area]			deficient practices below the 9	•	

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If continuation sheet

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPLI	ETED
		155697	A. BUII B. WIN			10/17/2	2012
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹			ITTLE LEAGUE BLVD		
CLADKE	DELIADII ITATIONI A	AND SKILLED NURSING CENTER			SVILLE, IN 47129		
	KEHABILITATION A	AND SKILLED NORSING CENTER		CLARK	SVILLE, IN 47 129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA:	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	q [every] 3 days	& prn [as needed]			threshold.Wound nurse and		
	soilage/dislodgement."				DNS/designee is responsible t ensure compliance.	.0	
					ensure compliance.		
	The Pressure Wound Skin Evaluation						
	Report, dated 10/15/12, indicated the						
	-	I was to the right buttock,					
		lly noted on 8/22/12, with					
		•					
		ne, 3.3 X 2.0 x 0.1 cm,					
	and without odo	r or drainage.					
	3. The clinical r	record for Resident S was					
	reviewed on 10/	17/12 at 9:20 a.m. The					
	record indicated	the resident was					
	readmitted from	the hospital on 10/5/12.					
		1					
	The Nursing Ad	mission Assessment,					
	_	ndicated with a check					
	•	ssment section for Skin					
		ound: pressure sore -					
		_					
	-	ructional notation on the					
		cated, "If areas of skin					
	integrity alteration	•					
	non-wound) are	noted on admission	1				
	measure each are	ea and complete a skin					
	sheet for each ar	rea." "Notes" on the					
	assessment indic	cated, "Dressing on					
	coccyx clean, dr	_					
	J 	J 9					
	A physician's or	der, dated 10/6/12,					
		as not limited to, "Cleanse					
		other day [symbol for					
		al saline], pat dry, cover					
		n] Allevyn for reddened					
	area."						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155697			LDING	00	COMPL	
		155697	B. WIN	IG		10/17/	2012
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
OL ADICE	DELLA DIL ITATIONI A	AND OWN FOR AN IDOMO OFFITE	_		ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	AND SKILLED NURSING CENTER	₹	CLARK	SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION)		TAG	DEFICIENCT)		DATE
	A D . 1 . 1 D	N 4 6					
		gress Note for nursing,					
		1:56 p.m., indicated,					
		noted to coccyx and tx					
		[continues] as ordered."					
		ation related to the wound					
		lent Progress Notes from					
	admission through	gh 10/11/12.					
		Administration Record					
		atment was started on					
		urse's initials next to the					
	*	nse coccyx q [every] other					
	1	with] NS [normal saline],					
		ymbol for with] Allevyn					
	for reddened are	ea."					
		rsing Summary and Skin					
	Assessment, date	ed 10/9/12, indicated, for					
	Skin Assessmen	t: warm and dry, pink,					
	and "none of the	above" related to skin					
	issues.						
	A physician's or	der for a hospice consult					
	was received on	10/11/12.					
	The hospice Nu	rsing Comprehensive					
	Admission Asse	ssment, dated 10/11/12,					
	indicated the res	ident had an unstageable					
	pressure ulcer to	the left upper buttock					
	measuring length	h X width X depth of 2.0					
	X 2.0 X U (unkr	nown or unstageable) cm.					
	Further descripti	ion of the wound was not					
	indicated on the						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155697			LDING	00	COMPL	
		155697	B. WIN	IG		10/17/	2012
NAME OF P	ROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP CODE		
			_		ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	AND SKILLED NURSING CENTE	₹	CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	-	nysician's orders were					
		eanse upper buttock					
	[symbol for with	n] soap & water, pat dry,					
	apply Santyl & o	dry dressing qd [every					
	day], [symbol fo	or change] PRN [as					
	needed] St. [Stag	ge] 4."					
	During interview	v on 10/17/12 at 5:40					
	_	or of Nursing Services					
	•	the coccyx wound was					
	,	eluding measurements,					
	· ·	on 10/5/12 through the					
		ent's admission to hospice					
		en the hospice nurse					
	· ·	-					
	assessed and me	asured the wound.					
	This fodoral to a	is related to Complaint					
	IN00117175.	is related to Complaint					
	1110011/1/3.						
	3.1-40(a)(2)						
	3.1-40(a)(2)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155697			LDING	00	COMPL	
		155697	B. WIN	G		10/17/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CLARK R	REHABILITATION A	ND SKILLED NURSING CENTER			ITTLE LEAGUE BLVD SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
F0329 SS=D	from unnecessary drug is any drug of dose (including dose (including dose (including dose (including; or with for its use; or in the consequences where the should be reduced combinations of the sased on a comparesident, the facily residents who has drugs are not given antipsychotic drug treat a specific condumented in the residents who use receive gradual dose drugs. Based on record facility failed to assessed related medication before and Ativan Interview and Ativan	DRUGS rug regimen must be free y drugs. An unnecessary when used in excessive uplicate therapy); or for on; or without adequate hout adequate indications ne presence of adverse nich indicate the dose d or discontinued; or any he reasons above. orehensive assessment of a ity must ensure that ive not used antipsychotic en these drugs unless g therapy is necessary to ondition as diagnosed and e clinical record; and e antipsychotic drugs iose reductions, and entions, unless clinically in an effort to discontinue review and interview, the ensure a resident was	F03	29	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident P passed awayHow other residents having the potential to be affected by the same deficien practice will be identified and what corrective action(s) will	n nt	11/16/2012
	Findings include The clinical reco	ord for Resident P was			be taken? All residents have the potential to be affected by the alleged deficient practice. Charaudit was completed by	ne	
	reviewed on 10/	10/12 at 10:15 a.m. The			DNS/designee to ensure residents on pain medication a	ire	

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG	00	COMPL	ETED
		155697	A. BUII			10/17/	2012
			B. WIN		ADDRESS STATE STATE STATE		
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
01.45145		NE OWN EE ANDERSON OF STREET			ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	AND SKILLED NURSING CENTER		CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	record indicated	the resident was admitted			assessed for pain with	ï	
	to the facility on	8/20/12 and was			documentation on the back of		
	1	e services at the time of			MAR for effectiveness.License		
		e services at the time of			nurses in-serviced on caring fo		
	admission.				the dying resident and assessi	ng	
					residents for pain	of	
	A hospice nurse	's note for 9/27/12 at			and documenting on the back the MAR including effectivenes		
	12:30 (a.m. or p.	.m. not indicated)			by the SDC/designee-post tes		
	indicated, "[Nan	ne of hospice] RN here			included. Non-compliance with		
		ated to report of patient			these practices will result in		
		e assessment completed.			further education including		
		-			disciplinary action.DNS/design	iee	
	_	abored respirations at 28			is responsible to ensure		
	X [times] min [r	ninute]. Shallow -			compliance.What measures w	/ill	
	reports pain but	unable to verbalize # on			be put into place or what		
	pain scale. Patie	ent appears to be starting			systemic changes will be ma	de	
	1 ^	r [daughter] at bedside.			to ensure that the deficient		
	1 2 2 1	fort for patient. [Name of			practice does not recur?Dyin	-	
					residents will be monitored each	_	
		and N.O.'s [new orders]			shift by DNS/designee to ensu		
	received. Please				pain assessments completed a	and	
	[medications] no	ot effective. Thanks.			pain medication given as ordered.Licensed nurses were		
					in-serviced on caring for the dy		
	Physician's orde	rs received 9/27/12 at			resident and assessing resider	-	
	1 -	cated, "[arrow pointing up			for pain and documenting on the		
	_	nol [narcotic pain			back of the MAR including		
	_	• •			effectiveness by the		
		mg/1 ml to 15 mg/0.75 ml			SDC/designee on (date), post		
		ır] PRN [as needed] SOA			included. Non-compliance with	1	
	[shortness of air]] Pain/restlessness SL			these practices will result in		
	[sublingual]/PO	[by mouth]. [Symbol for			further education including		
	changel Ativan	PO to Ativan Intensol			disciplinary action.DNS/design	iee	
	0 1	lication] 2 mg/1 ml give 1			is responsible to ensure		
	-	SL/PO PRN for			compliance. How the corrective		
		SL/PU FKIN IUI			action(s) will be maintained t	U	
	SOA/anxiety."				ensure the deficient practice will not recur, i.e., what quali	tv	
					assurance program will be p	-	
	Resident Progres	ss Notes for nursing,			into place?CQI audit for pain	ut	
	dated 9/29/12, at	t 4:25 p.m., indicated,			assessment will be completed		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155697	B. WING			10/17/	2012
	.n.o.v.n.n.n.o		1		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	t			ITTLE LEAGUE BLVD		
		ND SKILLED NURSING CENTER		CLARK	SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		<u> </u>		TAG	weekly x4, monthly x 6 and		DATE
	"Rested abed mo	-			quarterly thereafter. Findings fi	rom	
		ivan given thruout [sic]			the CQI process will be review		
		nead of bed] elevated to			monthly and an action plan wi		
		ng air. O2 [oxygen] on			implemented as needed for ar	-	
		nnula]. Has period of			deficient practice below the 95 threshold.DNS/designee is	0%	
		equently takes O2 off.			responsible to ensure		
		eave O2 on. Is presently			compliance.		
	resting with eyes	s closed.					
		4.0					
	_	record for 9/29/12					
		ident's respirations at					
		1 per minute. Vital					
	•	2 at 4:22 p.m., indicated,					
	blood pressure o	f 124/66, respirations 20					
	per minute, puls	e 64 per minute, and					
	temperature 97.7	degrees Fahrenheit. No					
	other vital signs	were indicated for					
	9/29/12.						
	The mayt Deside	nt Duo anaga Nata fan					
		nt Progress Note for					
	_	te entry on 9/30/12 at					
		/29/12 at 11:36 p.m., and					
		dent was able to open her					
	*	ame was called at 9:00					
	1 ^	in medication and ativan					
	~	ery hour to reduce pain					
	I -	9:30 p.m., resident was					
	1 ~	0.75 ml. and ativan 0.50					
	_	vas 56 bpm [beats per					
	minute] and her	O2 sat [saturation] was					
	94%. At 10:00 p.m., when entering the						
	room, noticed th	at resident had expired.					
	A second nurse	verified resident's death.					
	The doctor and I	NP [nurse practitioner]					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155697	B. WIN			10/17/	2012
			D. 11 II		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	AND SKILLED NURSING CENTE	3		SVILLE, IN 47129		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	was called and [name of hospice] was					
	called. Family v	was called directly					
	afterwards. The	ey requested to come in					
		dy. Awaiting the arrival					
	of the family."						
	or the running.						
	During interview	y on 10/10/12 of 1:50					
	_	v on 10/10/12 at 1:50					
	•	al Records Director					
		er assessments or vital					
	signs were avail	able for 9/29/12.					
	The narcotic rec	ord for Roxanol					
	indicated the me	edication was dispensed as					
	follows on 9/29)/12:					
	3:00 a m 6:00 a	a.m., 8:00 a.m., 9:00 a.m.,					
	-	p.m., 4:30 p.m., 5:35					
		8:30 p.m., and 9:30 p.m.					
	p.iii., 0.30 p.iii.,	8.50 p.m., and 9.50 p.m.					
	The narcotic rec	ord for Ativan Intensol					
		edication was dispensed as					
		/12: 3:00 a.m., 8:00 a.m.,					
		a.m., 1:00 p.m., 3:20					
	•						
	1	5:35 p.m., 6:30 p.m.,					
	8:30 p.m., and 9	7:30 p.m.					
	The Medication	Administration Record					
		cated four doses of the					
		ar doses of the Ativan					
	Intensol were a	dministered on 9/29/12.					
	Documentation	on the reverse was					
	lacking related t	o the Reason the as					
	_	ons were administered					
	and the Results/						
	medication.	response to the					
	medication.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					nstruction 00	(X3) DATE : COMPL	
		155697	A. BUI B. WIN	ILDING NG		10/17/	
	PROVIDER OR SUPPLIE	R AND SKILLED NURSING CENTE	₹	517 N L	ADDRESS, CITY, STATE, ZIP CODE ITTLE LEAGUE BLVD SVILLE, IN 47129		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	"Resident require to] end stage CO pulmonary disestincluded, but we "Administer pain orderedAsset verbal and nonbe available for comfort and supneeded" During interview p.m., the Directindicated the respain," and she wassess the reside administration of the resident was pain.	ss for sign of pain, both verbal; treat as indicated. resident/familyprovide oport. Notify Hospice as w on 10/11/12 at 3:20 or of Nursing Services sident "fluctuated with the would not expect a nurse to					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE S	SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155697	B. WING			10/17/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ITTLE LEAGUE BLVD		
CLARK R	REHABILITATION A	ND SKILLED NURSING CENTER			SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0425 SS=D	PROCEDURES, The facility must presidents, or obtate agreement descripart. The facility personnel to admipermits, but only supervision of a line. A facility must proservices (including the accurate acquispensing, and a and biologicals) to resident. The facility must of a line provides consultate provides consultate provides consultate provided medicate as ordered for 3 or related to narcotic in a sample of 21 H) Findings include 1. During interval. Resident Droutine pain mediand she can ask to a superprovide and she can ask to a superprovide	provide routine and and biologicals to its in them under an ibed in §483.75(h) of this may permit unlicensed inister drugs if State law under the general icensed nurse. Divide pharmaceutical g procedures that assure ulring, receiving, administering of all drugs of meet the needs of each employ or obtain the need pharmacist who ution on all aspects of the macy services in the facility. The review and interview, the ensure pharmacy tions for administration of 5 residents reviewed ic medication availability. 1. (Residents C, D, and	F04	25	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident D is recieving her pain medication as prescriand has a narcotic sheet in place. Resident H's pain medication is available and given as prescribed. Resident C's fentanyl patch has since been dc'd and pain assessment completed prior to dc'ing med. How other reside having the potential to be affected by the same deficier practice will be identified and what corrective action(s) will	ing bed ven onts	11/16/2012
	medication durin	ig me day. Kesident D			what corrective action(s) will be taken? All resident		

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Event ID: 9XMK11

Facility ID: 000059

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG	00	COMPL	ETED
		155697	A. BUII		-	10/17/	2012
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
		AND OKULED NUIDOING OFNITED			LITTLE LEAGUE BLVD		
CLARK	REHABILITATION A	AND SKILLED NURSING CENTER		CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	indicated her rig	tht knee hurts her. She			MAR's/TAR's audited to ensur		
	indicated pharm	acy doesn't always send			all physician orders/medicatio		
	the medication t	imely. She indicated she			are listed correctly and that all medications are available.All		
		rse tells her "pharmacy			residents have the potential to	ho	
	hasn't sent it yet				affected by the alleged deficie		
	liasii i sciii ii yei	•			practice.Licensed nurses		
	m	10 D 11 15			in-serviced on		
		ord for Resident D was			adminsitering/re-ordering		
	reviewed on 10/	15/12 at 4:05 p.m.			medications timely and EDK		
					protocols by the SDC/designe	е	
	Physician's orde	ers for September 2012			on (date), post test		
	I -	ere not limited to, an order			included. MAR's/TAR's are		
	originally receiv	•			monitored weekly by the management nurses to ensure		
	"	min 5-500 mg tab			availabilty of medications and	5	
	*	•			narcotic sheets present and		
		nedication], take 1 tablet			utilized.DNA/designee will rev	iew	
	1 -	daily at 9:00 a.m. for			monthly pharmacy narcotic us		
	chronic leg pain	" and "Hydroco/Acetamin			report to monitor EDK narcotic		
	5-500 mg tab, ta	ike 1 tablet by mouth			usage.Non-compliance with the	nese	
	every 4 hours as	needed for pain."			practices will result in further		
	,	•			education including disciplinar	У	
	The Medication	Administration Record			action.DNS and wound	to	
		tember 2012 indicated the			nurse/designee is responsible ensure compliance. What	ιο	
		d the routine dose of			measures will be put into pla	ice	
					or what systemic changes w		
	_	edication daily in			be made to ensure that the		
	_	, except on 9/24/12 and			deficient practice does not		
	9/25/12. On the	se dates, the initials of the			recur?All resident MAR's/TAF	₹'s	
	nurse who was t	o administer the			audited to ensure all physiciar	1	
	medication were	e circled to indicate the			orders/medications are listed		
		not administered. No			correctly and that all medication	ons	
		he omission was written			are available. Licensed		
	-	ide of the MAR. The			nurses-in-serviced on		
					adminsitering/re-ordering medications timely and EDK		
	reverse side of the MAR indicated with				protocols by the		
		I #5 obtained the			SDC/designee-post test		
		the Pixus emergency			included. MAR's/TAR's are		
	drug supply on 9	9/26/12, but the initials on			monitored weekly by the		

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		155697	B. WIN			10/17/	2012
		1	B. WII		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	AND SKILLED NURSING CENTER	2		SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	the record of ad	ministration on that date			management nurses to ensure	;	
	indicated the me	edication was			availabilty of medications and		
	administered by	LPN #15			narcotic sheets present and		
		ETT (113.			utilized. Non-compliance with		
	Dagidant Dragna	as Notes for 0/24 and			these practices will result in further education including		
	•	ss Notes for 9/24 and			disciplinary action.DNS/design	iee	
		documentation related to			will review monthly pharmacy		
	the medication r	not being administered.			narcotic usage report to monitor EDK narcotic usage.DNS and	or	
	The Narcotic Co	ount Record for Resident			wound nurse/designee is		
	D lacked docum	entation of the			responsible to ensure		
		cetaminophen for the			compliance. How the corrective		
	1 -	ough 9/27/12, although			action(s) will be maintained t	0	
		was documented as			ensure the deficient practice		
					will not recur, i.e., what quali	-	
		those dates, except for			assurance program will be po	ut	
	9/24 and 9/25/12	2.			into place?CQI pharmacy services tool will be utilized		
					weekly x 4, monthly x 6 and		
	During interview	v on 10/17/12 at 3:00			quarterly thereafter.Findings fr	om	
	p.m., the Directo	or of Nursing Services			the CQI process will be		
	* '	I she had researched, and			reviewed monthly and an actic		
	` ′	ord to explain why the			plan will be implemented for a		
		not administered on 9/24			deficient practices below the 9	5%	
		ne indicated a Narcotic			thereshold DNS/designee is		
					responsible to ensure compliance.		
		as not available for the			Compilation.		
		ough 9/27/12, but she did					
	not know why.						
	2. The clinical i	record for Resident H was					
	reviewed on 10/	15/12 at 1:30 p.m.					
		•					
	Physician's orde	ers for September 2012					
	-	ere not limited to, an order					
	· ·						
	originally receiv	-					
		etaminophen 10-325 tab,					
	take 1 tablet by	mouth every 4 hours -					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		NSTRUCTION 00	(X3) DATE S COMPL	ETED	
		155697	B. WING			10/17/	2012
	PROVIDER OR SUPPLIEI REHABILITATION A	NO SKILLED NURSING CENTER		517 N L	DDRESS, CITY, STATE, ZIP CODE ITTLE LEAGUE BLVD SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	T -	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PI	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	increased pain."						
	circles around the following sched Oxycodone/Ace 9:00 p.m., and 9 5:00 a.m. The rindicated, "9/8/1 10/325 [symbol EDK [emergence aware, to send R 1A [1:00 a.m.] [Percocet 10/325 4A [4:00 a.m.] 7 3. The clinical in	eptember 2012 indicated are nurse's initials for the uled doses of the taminophen: 9/8/12 at /9/12 at 1:00 a.m. and reverse side of the MAR 2 9P [9:00 p.m.] Percocet for not] avail [available] y drug kit] depleted, MD ax [prescription]. 9/9/12 ditto marks under Awaiting Rx. 9/9/12 Gylenol 650 mg pain."					
	included, but we originally receive 50mcg/hr [narco	rs for September 2012 ere not limited to, an order red 8/4/12 for "Fentanyl otic pain medication nsdermally], apply 1 every 72 hours."					
	The MAR for So the nurses' initial entry for Fentan the following day 9/23/12. The reindicated the following patch:	eptember 2012 indicated ls were circled next to the yl patches scheduled on tes: 9/14, 9/17, 9/20, and werse side of the MAR lowing related to the "9/17 Patch [symbol for pharm [pharmacy]					

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Event ID: 9XMK11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155697	B. WIN			10/17/	2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
		ND SKILLED NURSING CENTER	.		ITTLE LEAGUE BLVD		
			<u> </u>	CLARK	SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG		·		TAG	BETTELLINETY		DATE
		2 MD aware of need for					
	new script."						
	Danidant Dua ana	Natas fan 0/14 thussal					
		ss Notes for 9/14 through					
		ocumentation related to					
	the unavailable r	neulcation.					
	Dumin = ind : :	r on 10/17/10 at 2:00					
	_	on 10/17/12 at 3:00					
	-	idicated the Narcotic					
		owed the Fentanyl was					
		9/14/12 but not on the					
		DNS was uncertain why					
		ls on 9/14/12 appeared to					
	be circled.						
	_	is related to Complaint					
	IN00117175.						
	3.1-25(a)						

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Facility ID: 000059

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					NSTRUCTION 00	(X3) DATE S COMPL	
		155697	A. BUILDIN B. WING	IG		10/17/	2012
				TREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	{	5	17 N LI	TTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	AND SKILLED NURSING CENTER	R	LARKS	SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES	II		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	ICY MUST BE PRECEDED BY FULL	PRE	AG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
F0431	483.60(b), (d), (e	R LSC IDENTIFYING INFORMATION)	17	AG	DEFICIENCE)		DATE
SS=D	& BIOLOGICALS The facility must services of a lice establishes a system and disposition of sufficient detail to reconciliation; and records are in order all controlled drug periodically record Drugs and biologomust be labeled accepted professinclude the approcautionary instruction accordance with the factorial of the service of the se	employ or obtain the nsed pharmacist who stem of records of receipt of all controlled drugs in the enable an accurate of determines that drug der and that an account of the enable and th					
	biologicals in lock proper temperatu authorized perso keys.	ked compartments under ure controls, and permit only nnel to have access to the provide separately locked,					
	permanently affix storage of control Schedule II of the Abuse Prevention and other drugs when the facility drug distribution	ted compartments for alled drugs listed in the Comprehensive Drug on and Control Act of 1976 subject to abuse, except uses single unit package systems in which the siminimal and a missing					
	facility failed to established an ac	review and interview, the ensure pharmacy ccurate process for onciling narcotic	F0431		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?Resident J is recieving	1	11/16/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLETED
		155697	B. WIN			10/17/2012
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEF	₹			ITTLE LEAGUE BLVD	
CLARK F	REHABII ITATION A	AND SKILLED NURSING CENTER			SVILLE, IN 47129	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	· ·	DATE
		ne deficient practice			pain medication as prescribed. How other resider	nte.
		residents reviewed related			having the potential to be	11.5
	to narcotic medi	cation administration in a			affected by the same deficier	nt
	sample of 21. (I	Residents J)			practice will be identified and	
					what corrective action(s) will	
	Findings include	<u>.</u>			be taken?All residents have the	
	32 2222444				potential to be affected by the	
	The clinical root	ord for Resident J was			alleged deficient practice.All	
					residents MAR's/TAR's audited	d to
	l reviewed on 10/	15/12 at 5:00 p.m.			ensure all physician orders/medications are listed	
					correctly and that all medication	une.
	1 -	rs for September 2012			are available.All resident narco	
	included, but we	ere not limited to, an order			sheets and on-site medication	
	originally dated	3/23/12, for			audited to ensure documentati	
	"Hydroco/Aceta	min 500 mg tab [narcotic			reflects correct amount of	
	pain medication	, take 1 tablet by mouth			medication has been	
	once daily routing	•			dispensed.Licensed nurse's	
	1	min 500 mg tab, take 1			in-serviced on documenting	
	1 -	every 6 hours as needed			narcotic pain medications on the correct narcotic count sheet ar	•
	1	-			administering narcotic pain	iu
	for moderate pai	ın			medications as prescribed.MA	R's
					and TAR's are reviewed week	
		Administration Record			by the managment nurses to	
	for September 2	012 indicated the narcotic			ensure medications are given	as
	pain medication	was administered at 9:00	1		prescribed and narcotic count	h.
	a.m. daily on Se	ptember 1 through			sheets are utilized appropriate for routine/non-routine	ıy
	September 30, 2	012. The reverse side of			medications. Non-compliance	
		ted the 9:00 a.m. dose			with these practices will result	in
		om the Emergency Drug			further education including	
	Kit on 9/4/12.	Emergency Drug			disciplinary action.DNS/design	iee
	1XII 011 7/4/12.				is responsible to ensure	
	Th. MAD C. C.				compliance. What measures w	/ill
		eptember 2012 indicated			be put into place or what	.1.
	-	medication was			systemic changes will be ma	ae
	administered 8 t	imes on an as-needed			to ensure that the deficient	
	basis.				practice does not recur?All residents MAR's/TAR's audited	d to
					ensure all physician	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPLETED	
		155697	B. WIN			10/17/2012	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	L			ITTLE LEAGUE BLVD		
CLARK F	REHABII ITATION A	ND SKILLED NURSING CENTER			SVILLE, IN 47129		
						1	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	· ·	CY MUST BE PRECEDED BY FULL		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE	
TAG		LSC IDENTIFYING INFORMATION)		TAU	orders/medications are listed	DATE	
	-	arcotic Count Sheets were			correctly and that all medication	ine	
	maintained - one				are available.All resident narco		
		00 a.m. and one for the			sheets and on-site medication		
	as-needed medic	ation. The Narcotic			audited to ensure documentati	on	
	Count Sheet for	routine doses, with dates			reflects correct amount of		
	from 8/11/12 thr	ough 9/1/12, indicated			medication has been		
		ed for non-routine doses 9			dispensed. Licensed nurse's		
		cotic Count Sheet for			in-serviced on documenting narcotic pain medications on the	ne	
		with dates from 9/11/12			correct narcotic count sheet ar	•	
		2, indicated the sheet was			administering narcotic pain		
	_	ine 9:00 a.m. doses on all			medications as prescribed.MA	R's	
					and TAR's are reviewed week	у	
		through 9/30/12. No			by the managment nurses to		
		Sheet indicated the			ensure medications are given	as	
	narcotic medicat	ion was administered on			prescribed and narcotic count sheets are utilized appropriate	lv	
	9/4 through 9/10	/12.			for routine/non-routine	iy	
					medications. Non-compliance		
	During interview	v on 10/17/12 at 3:00			with these practices will result	in	
	_	or of Nursing Services			further education including		
	_	entation a dose of the			disciplinary action.DNS/design	ee	
	•	obtained from the			is responsible to ensure		
		supply on 9/10/12, when			compliance. How the corrective		
		ted the routine dose was			action(s) will be maintained t ensure the deficient practice	o	
					will not recur, i.e., what quali	tv	
	administered at 9				assurance program will be p	-	
		at 5:00 p.m. She			into place?CQI audit for		
		ald not account for where			pharmacy services will be utilize	zed	
		ame from for the routine			weekly x4, monthly x 6 and		
	medication dose	s on 9/5, 9/6, 9/7, 9/8,			quarterly thereater. Findings fro		
	and 9/9/12. She	indicated the pharmacy's			the CQI process will be review monthly and an action plan wil		
	policies related t	o narcotic medications			implemented as needed for an		
	•	rst of September and			deficient practice below the 95		
	there had been a	•			threshold.DNS/designee is		
	communication	•			responsible to ensure		
	Communication	with pharmacy.			compliance		
	This federal tag	is related to Complaint					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/19/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 10/17/2012
	PROVIDER OR SUPPLIE	R AND SKILLED NURSING CENTER	517 N L	ADDRESS, CITY, STATE, ZIP CODE LITTLE LEAGUE BLVD SVILLE, IN 47129	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	IN00117175.				
	3.1-25(n)				

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Event ID: 9XMK11

Facility ID: 000059

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155697	B. WIN			10/17/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	t e e e e e e e e e e e e e e e e e e e			ITTLE LEAGUE BLVD		
CLARK R	FHARII ITATION A	ND SKILLED NURSING CENTER			SVILLE, IN 47129		
				<u> </u>	5 VILLE, IIV 47 129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0441	483.65						
SS=E		ITROL, PREVENT					
	SPREAD, LINEN						
	•	establish and maintain an Program designed to					
		anitary and comfortable					
		to help prevent the					
		transmission of disease					
	and infection.						
	(a) Infection Cont	rol Program					
	•	establish an Infection					
	Control Program						
		controls, and prevents					
	infections in the fa	•					
		procedures, such as be applied to an individual					
	resident; and	be applied to all illulvidual					
	·	ecord of incidents and					
	· ·	s related to infections.					
	(b) Preventing Sp	read of Infection					
	(1) When the Infe	ection Control Program					
		resident needs isolation to					
		nd of infection, the facility					
	must isolate the r						
		ust prohibit employees with					
		disease or infected skin					
		ct contact with residents or t contact will transmit the					
	disease.	t contact will transmit the					
		ust require staff to wash					
		each direct resident contact					
		ashing is indicated by					
	accepted profess	•					
	(c) Linens						
		nandle, store, process and					
		o as to prevent the spread					
	of infection.	ation to an in the	F0.4	41			11/1/2010
		ation, interview, and	F04	41	What corrective action(s) will		11/16/2012
	record review, th	ne facility failed to ensure			be accomplished for those		

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Event ID: 9XMK11

Facility ID: 000059

If continuation sheet

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		nn.a	00	COMPL	ETED
		155697	A. BUII			10/17/	2012
			B. WIN	_	ADDRESS SITY STATE TIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
	DELLA DILITATIONI A	AND OKULED AUTDOING OFFITED			LITTLE LEAGUE BLVD		
CLARK	REHABILITATION A	AND SKILLED NURSING CENTER		CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
	infection control	l policies were followed			residents found to have been	n	
	related to emplo	yee screening for			affected by the deficient		
	_	-			practice?No residents were		
	tuberculosis, handwashing/glove use, and isolation precautions. The deficient				affected by the alleged deficie	ent	
	-				practice related to TB		
	•	to tuberculosis affected 4			screening.Resident I is no lon	ger	
		whose files were reviewed			in contact isolation Employee 6,2,5,and 21 have completed	TR	
		ing for tuberculosis. The			skin test How other residents		
	deficient practic	e related to			having the potential to be	-	
	handwashing/iso	olation precautions			affected by the same deficie	nt	
	_	esident reviewed related			practice will be identified an		
		Clostridium difficile			what corrective action(s) wil		
					be taken?All residents have the		
	infection in a sar	inple of 21.			potential to be affected by the		
					alleged deficient practice.Aud	it	
	Findings include	2:			completed on all employee		
					records to ensure all employe	es	
	1. The facility's	policy related to			have completed TB skin		
	-	ening - Tuberculosis			tests.SDC in-serviced 1:1 on	·	
		ded by the Nurse			proper TB skin test protocols	ror	
					new hires.Nursing staff in-serviced on infection control	d.	
		0/15/12 at 1:00 p.m. The			practices for residents in isola		
		, "All employees will be			hand washing and glove use I		
	screened for TB	in accordance with state			the SDC/designee-post test	- ,	
	and federal regu	lations." The policy			included.Skills validations for		
	indicated newly	hired employees would			hand washing/glove use/prope	er	
	1	he two-step testing			isolation procedures will be		
	_	ring an initial skin test			completed on or before (date)	by	
					the SDC/designee.Audit		
	1	econd skin test 1 to 3			completed on c.n.a. assignme	ent	
	· ·	ess the employee had a			sheets to ensure they include type of isolation for any reside	nt	
	1	gative TB test within the			in isolation to ensure c.n.a.'s		
	preceding 12 mg	onths.			aware for care of the	0	
					resident.Audit completed to		
	Employee files	were reviewed on			ensure all residents in isolatio	n	
	10/11/12 at 9:55				have their rooms properly		
	10/11/12 at 9.33	a.111.			identified to be in isolation alo	ng	
					with having the proper isolation	n	
	A. The file for 0	CNA #6 indicated a hire			precaution supplies stationed		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG	00	COMPLI	ETED
		155697	A. BUII		·	10/17/	2012
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIEI	₹			ADDRESS, CITY, STATE, ZIP CODE		
OL A DIV E	SELLA DILITATIONI	AND OKULED AUIDOINO OFAITED			ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	AND SKILLED NURSING CENTER		CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	date of 7/24/12.	The file lacked			outside each isolation		
	documentation of	of CNA #6's second step			room.Non-compliance with the	ese	
	TB skin test. B. The file for CNA #2 indicated a hire date of 7/31/12. The file lacked				practices will result in further		
					education including disciplinar	У	
					action.DNS/designee is responsible to ensure		
					compliance. What measures w	,;;;;	
					be put into place or what	VIII	
	documentation of	of CNA #2's second step			systemic changes will be ma	اما	
	TB skin test.				to ensure that the deficient	ue	
					practice does not recur?Audi	it I	
	C The file for I	LPN #5 indicated a hire			completed on all employee		
	date of 8/5/11.				records to ensure all employee	es	
					have completed TB skin		
		of LPN #5's second step			tests. SDC in-serviced 1:1 on		
	TB skin test.				proper TB skin test protocols f	or	
					new hires.ED will monitor all n	ew	
	D. The file for l	RN #21 indicated a hire			hires to ensure all new		
	date of 6/6/12.	The file lacked			employees have been given T	В	
		of RN #21's second step			test prior to hire and 2nd step		
		or Kin #21's second step			within 21 days of hire.Nursing staff in-serviced on infection		
	TB skin test.				control practices for esidents in	n	
					isolation, hand washing and gl		
	During the Daily	y Conference on 10/11/12			use by the SDC/designee-pos		
	at 4:15 p.m., the	Administrator indicated			test included. Skills validations		
	the facility had i	no other records of TB			hand washing/glove use/prope	er	
	skin tests.				isolation procedures will be		
	SKIII tests.				completed on or before (date)	by	
	2 D . 1	1.T. 10/10/12 / 4.00			the SDC/designee.Audit		
	_	1 Tour on 10/10/12 at 4:00			completed on c.n.a. assignme	nt	
		indicated he would need			sheets to ensure they include		
	to check to be su	are but thought Resident I			type of isolation for any reside in isolation to ensure c.n.a.'s a		
	was on isolation	precautions related to			aware for care of the	ii C	
	VRE (Vancomy	cin Resistant			resident.Audit completed to		
	Enterococcus) in the urine.				ensure all residents in isolation	,	
		· ····································			have their rooms properly		
	Demin a last and i	10/10/12 -4 7:20			identified to be in isolation alor	ng	
	_	v on 10/10/12 at 7:20			with having the proper isolation	~	
	1	dicated Resident I's			precaution supplies stationed		
	isolation was rel	ated to VRE of the urine,			outside each isolation		

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		155697	B. WIN			10/17/2012
			D. ((11)		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEF	L			ITTLE LEAGUE BLVD	
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER			SVILLE, IN 47129	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		as contained because the			room. Non-compliance with the practices will result in further	ese
	resident had a Fo	oley catheter.			education including disciplinar	v
					action.DNS/designee is	,
	During interview	v on 10/15/12 at 10:40			responsible to ensure	
	a.m. at the bedsi	de of Resident I, CNA			compliance. How the corrective	
	#14 indicated sh	e was preparing to check			action(s) will be maintained t	
	to see if Residen	t I had a bowel			ensure the deficient practice	
	movement and n	eeded care.			will not recur, i.e., what quali assurance program will be p	-
					into place?CQl audit tool for	
	On 10/15/12 at	10:55 a.m., CNAs #12			infection control will be utilized	
		served providing			weekly x4, monthly x6 and	
		for Resident I. Both			quarterly thereafter.CQI TB at	
		ring gloves, and neither			tool for employee records will	
		ng an isolation gown to			utilized weekly x4, monthly x6 quarterly thereafter. Findings fr	
		m. Resident I had been			the CQI process will be review	
					monthly and an action plan wil	
		tool and was cleansed and			implemented as needed for ar	-
		A #14. During care, CNA			deficient practice below the 95	
		ide to attend to another			threshold. DNS and Executive Director/designee are respons	
		[‡] 14 completed the			to ensure compliance.	ible
		and without changing			to onedro compilarios.	
	_	ng her hands, proceeded				
		lent into a clean gown,				
	replace the bed	covers, manipulate the				
	call light and TV	remote, and arrange the				
	overbed table. (CNA #14 then washed her				
	hands and left th	e room to get the nurse.				
	Shortly afterwar	ds, RN #17 and CNA #14				
	<u>-</u>	wearing gloves and				
		During interview at this				
	_	dicated the resident was				
	on isolation for C-diff (Clostridium					
		-				
1	CNA #14 indica	ia causing diarrhea). ted she had not worn an uring incontinent care				

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Facility ID: 000059

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPL	ETED
		155697	A. BUII B. WIN	LDING		10/17/	2012
		<u> </u>	B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹			ITTLE LEAGUE BLVD		
CLARKE	PEHARII ITATION A	AND SKILLED NURSING CENTER)		SVILLE, IN 47129		
			`		OVILLE, IIV 47 123		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
ı		In't know about the C-diff					
1	- it's new to me.'	'					
	The clinical reco	ord for Resident I was					
	reviewed on 10/	15/12 at 12:45 p.m.					
	A physician's or	der, dated 10/6/12,					
	included, but wa						
		ays r/t [related to] C-diff -					
	1	culture] X 2 [two times]					
	^ -	r] Flagyl." The Care Plan					
		of the physician's order					
	_	vention related to C-diff,					
	"Contact isolation	on."					
	The facility's no	lior for "Infaction Control					
		licy for "Infection Control					
		was provided by the					
		nt on 10/15/12 at 1:00					
		indicated in the section					
	on "Standard Pro	-					
		nge gloves during care if					
		from a contaminated site					
	to a clean site."	The "Contact					
	Precautions," see	ction indicated, "Use of					
	Personal Protect	ive Equipment - Gown:					
	Put on a gown	upon entry to					
	"	rotects clothing from					
	_	nination from direct					
	1 ^	dent, environmental					
	surfaces or equip	· · · · · · · · · · · · · · · · · · ·					
	Sarraces of equip	y					
	The facility's "U	andwashing Policy and					
		provided by the Nurse					
	Consultant on 10	0/15/12 at 1:00 p.m. The					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/19/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE S COMPL		
		155697		LDING		10/17/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	L	
NAME OF P	ROVIDER OR SUPPLIEF	R			ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	AND SKILLED NURSING CENTER	2	CLARK	SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
IAG		LSC IDENTIFYING INFORMATION)	1	TAG	DEFICIENCT)		DATE
		, "Purpose: 1. To prevent					
	the spread of inf	lure:5. Decontaminate					
		from a contaminated					
		ean body site during					
	patient care"	can oody sice during					
	patient care						
	This federal tag	is related to Complaint					
	IN00117175.	r					
	3.1-14(t)(1)						
	3.1-18(a)(2)						
	3.1-18(1)						
			1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED	
		155697	B. WIN			10/17/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER	S.			LITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTE	₹		(SVILLE, IN 47129		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	VIE.	DATE
F0465	483.70(h)						
SS=F	SAFE/FUNCTION TABLE ENVIRON	NAL/SANITARY/COMFOR N					
	The facility must	provide a safe, functional,					
	sanitary, and com residents, staff ar	nfortable environment for					
		ation and record review,	F04	65	What corrective action(s) will	II	11/16/2012
		I to ensure a sanitary and			be accomplished for those	•	11,10,2012
	_	•			residents found to have been	n	
		ironment by keeping			affected by the deficient		
		dust, cobwebs, and			practice? The radiators of 12		
		ing leaks/replacing			residents (Rm 7(2 residents),	Rm	
	_	les, and by keeping the			50(1 resident), Rm 22(2		
	kitchen floors cle	ean, sink faucet repaired,			residents), Rm 29(2 residents),	
	and shelves rust-	free. The deficient			Rm 25(2 residents), Rm 60(2 residents), and Rm 20(1		
	practice affected	12 of 12 residents whose			resident), have been cleaned,		
	radiators were ol	oserved, residents using			serviced and filters installed.T		
	the 60 and 20 ha	lls where the ceiling tiles			stained ceiling tiles on halls 60		
		d residents served from			and 20 have been replaced.Ti		
	the facility's kitc				fan/vent in the dishroom has t		
	the facility 5 kite	nen.			cleaned, shelves purchased to replace those rusted. Leaking		
	Eindings include				faucet has been repaired. How	-	
	Findings include	·			other residents having the	•	
	1 0 10/11/10				potential to be affected by th	ie	
	1. On 10/11/12	· ·			same deficient practice will I		
	•	ovided a list labeled			identified and what corrective	e e	
	PTAC (Package	d Terminal Air			action(s) will be taken? All		
	Conditioner) Cle	eanout List. The			residents have the potential to		
	Administrator in	dicated the Maintenance			affected by the alleged deficie	ent	
	Director was wo	rking on the radiator			practice.All facility radiators inspected/serviced/cleaned ar	nd	
		ity. The Administrator			filters placed.All facility halls	iu	
		next to room numbers			inspected and stained ceiling	tiles	
		liators not yet "complete"			replaced.Kitchen and dishrooi		
		eview of the list indicated			area inspected, all fans/vents		
					cleaned. All shelving inspects	ed	
	the units were "	*			for rust. Customer Care Rep	ont	
	_	: Room 20, Room 22,			rounds continued by Departm Managers to not only	ent	
	Room 25, and R	Room 29.			communicate with residents, b	out	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION 00			(X3) DATE SURVEY COMPLETED		
ANDILAN	OF CORRECTION		A. BUI	LDING	00		
		155697	B. WIN	IG		10/17/	2012
NAME OF I	DOLUBED OF GUIDNI IEE		-	STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	C .		517 N L	LITTLE LEAGUE BLVD		
CI ARK F	REHABII ITATION A	AND SKILLED NURSING CENTER					
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					to also identify areas for		
	During an enviro	onmental tour with the			Maintenance to address.All st	aff	
	_	rector on 10/11/12			inserviced on		
					identifying/communicating		
		.m. and 11:50 a.m., the			environmental concerns. A ne		
	following was o	bserved:			Maintenance request form wa		
					implemented to communicate		
	A. In Room 7 (t	two residents), the front of			concerns to the appropriate st		
	the radiator was				Residents were presented wit		
		•			the new Maintenance request		
		rector. The filter on the			form in residesnt council.Maintenance Director,		
	unit was clean.	In the floor of the radiator			Housekeeping Supervisor and		
	were a toy footb	all, toy car, small doll toy,			Dietary Manager in-serviced 1		
	and a wound me	asuring device, all laden			on preventative maintenance	. 1	
		nterior of the unit was			program and providing a sanit	arv	
					comfortable environment.	.u.y	
	<u>-</u>	th thick gray dusty spider			Non-compliance with preventa	ative	
		nterview at this time, the			maintenance program will res		
	Maintenance Di	rector indicated the			in further education including		
	radiator was "in	bad shape."			disciplinary		
		•			action.Maintenance/designee	is	
	R In Room 50	(one resident), the front of			responsible to ensure complia		
					with preventative maintenance		
	the radiator was	•			program.What measures will		
		rector. The unit had no			put into place or what system	nic	
	filter in place. V	Within the unit were			changes will be made to		
	plastic bags, and	l dust, debris, and spider			ensure that the deficient		
	webs were throu	ighout the interior.			practice does not recur? New	N	
		6			Maintenance request form		
	C In Danie 22	(ture medidants) the form			implemented to communicate maintenance needs. Both sta		
		(two residents), the front			and residents informed of	П	
		as removed by the			new communication		
	Maintenance Di	rector. The unit had no			tool.Maintenance Director,		
	filter in place. T	The inside of the cover			Housekeeping/Laundry		
	_	ebbed. Black areas were			Supervisor and Dietary Manag	ger	
		the Maintenance			in-serviced 1:1 on preventativ	•	
	· · · · · · · · · · · · · · · · · · ·				maintenance and providing a		
		ed might be concentrated			sanitary comfortable		
	dust and dirt.				environment.Non compliance	will	
					result in further education		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155697			LDING	00	(X3) DATE COMPL 10/17/	ETED		
	PROVIDER OR SUPPLIER	I ND SKILLED NURSING CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR D. In Room 29	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) (two residents), the front		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) including disciplinary		(X5) COMPLETION DATE	
	cover of the radi Maintenance Din had a light coatin Maintenance Din filters once a mon the interior cove the unit's fan bla E. In Room 25 (cover of the radi Maintenance Din soiled with dust, back of the cove candy wrapper with thick dust a the unit's fan bla F. In Room 60 (cof the radiator with thick dust) Maintenance Din covered with thi	ator was removed by the rector. The unit's filtering of dust. The rector indicated he checks onth. Thick dust was on r, and paper debris was in des. (two residents), the front ator was removed by the rector. The filter was Thick dust was on the r. A dryer sheet and vere inside the unit, along and webs. Tissues were in des. (two residents), the front as removed by the rector. The filter was ck dust. Paper, tissues,			action.Maintenance/designeeresponsible to follow preventa maintenance program How the corrective action(s) will be maintained to ensure the deficient practice will not rei.e., what quality assurance program will be put into place? Customer Care Rep Rounds to be done daily M-Fongoing.CQI audit tool for a sanitary and comfortable environment will be utilized weekly x4, monthly x6 and quarterly thereafter.Executive Director/designee is resposible ensure compliance.	ative e cur,		
	blades. G. In Room 20 Maintenance Director of the radifilter. A light coinside of the front floor of the unit. 2. During the En	(one resident), the rector removed the front ator. The unit had no pating of dust was on the nt cover. Dust was on the nvironmental Tour on 1:00 a.m. to 11:50 a.m.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SUR	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETE	
		155697	B. WIN	G		10/17/201	12
NAME OF P	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTE	R	CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	re CC	OMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		nance Director, the					
	following was ol	bserved:					
	I -	ile in the hallway outside					
	Room 60 was sta	ained with brown,					
		arks. During interview at					
		aintenance Director					
	_	inkler system had leaked					
	in that spot, and	had now been repaired.					
	B. The ceiling ti	ile in the hallway outside					
	Room 31 was sta	ained with brown,					
	circular water m	arks. The Maintenance					
	Director indicate	ed he had located a leak					
	on the roof, had	put tar on it for repair but					
	l '	on it." The Assistant					
		ing was interviewed at					
		licated it had been a "long					
		acility had to use blankets					
		atch water in that area.					
	3. The following	g was observed in the					
		facility's kitchen on					
		p.m.: dishroom:					
		Present description					
	A. The overhead	d fan/vent was covered					
		king black substance.					
	_	at this time, the Dietary					
	_	ed the Maintenance					
ı	Director cleans t						
	Director cicuits t	110 1011/ 1 011/.					
	B The wide she	elves holding the plastic					
		rusted through along the					
	edges.	rabica unough along the					
	Luges.		1				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/19/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER: 155697	A. BUII B. WIN	LDING	00	COMPL: 10/17/	ETED
NAME OF B	DOWNER OF GUIDNI IED		b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
	ROVIDER OR SUPPLIER				ITTLE LEAGUE BLVD		
		ND SKILLED NURSING CENTER		CLARK	SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	*	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
	C. The faucet of leaking, and wate wall and out into Dietary Manager faucet was on ord	the rinse sink was er was running down the the floor drain. The indicated a part for the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155697	B. WIN	G		10/17/	2012
	ROVIDER OR SUPPLIER	ND SKILLED NURSING CENTER		517 N L	ADDRESS, CITY, STATE, ZIP CODE LITTLE LEAGUE BLVD SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0518 SS=F	emergency proce work in the facility procedures with e unannounced sta procedures. Based on intervie facility failed to		F05	18	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient		11/16/2012
	potential fire em	ergency. The deficient			practice? No residents were		
	practice had the	potential to affect 70 of			affected by the alleged deficier	nt	
	70 residents resi	iding in the facility.			practice. How other residents		
	Findings include	:			having the potential to be affected by the same deficier practice will be identified and what corrective action(s) will	i	
	During interview	on 10/10/12 at 9:35			be taken? All residents have the		
	a.m., the Mainter	nance Director indicated			potential to be affected by the		
	recently the Fire	Department had been			alleged deficient practice.All st		
	called to the buil	ding. The Maintenance			in-serviced by SDC/designee of	on	
	Director indicate	ed he had heard			the emergency procedure for potential fire emergency-post t	est	
	everything from	"flames shooting out" to			includedFire drills conducted b		
		g" was seen in Room 10.			Maintenance/designee on all 3	3	
		e Director indicated the			shifts to ensure emergency fire	9	
		iator was faulty and			procedure is being followed.Non-compliance with		
	•	possibly created a puff of			these practices will result in		
	smoke.	vession, eremou a pair er			further education including		
	2111011 0 .				disciplinary action.Maintenance	е	
	During intervious	on 10/11/12 at 8:30			Director/dsesignee is responsi	ble	
	_	r of Nursing Services			to ensure compliance. What		
	· ·	•			measures will be put into pla or what systemic changes wi		
		LPN #9 called her at			be made to ensure that the	111	
		ng to ask the DNS			deficient practice does not		
		ne Fire Department when			recur? All staff in-serviced by		
	smoke was comi	ng from the radiator in					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		A. BUILDING 00		COMPLETED		
	155697		B. WING			10/17/2012		
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIER	8		1				
OLADIZ DELIADILITATION AND OZULI ED NUDOINO CENTED				517 N LITTLE LEAGUE BLVD				
CLARK REHABILITATION AND SKILLED NURSING CENTER			CLARKSVILLE, IN 47129					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO		TE (COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE	
	Room 10. The DNS indicated she told				SDC/designee on the emerger	псу		
	LPN #9 to call, since it was better to be			procedure for potential fire emergency-post test included.Fire				
	safe than sorry.					Fire		
				drills conducted by				
	5				Maintenance/designee on all 3			
	During interview on 10/17/12 at 4:05			shifts to ensure emergency fire				
	p.m., LPN #9 indicated on the evening of			procedure is being followed. Non-compliance with				
	the Fire Department visit, she was just coming in from her break, and staff called her to Room 10, because there were				these practices will result in			
					further education including			
					disciplinary action. How the			
	sparks from the radiator. LPN #9				corrective action(s) will be			
	indicated she went into the room, and the				maintained to ensure the			
	ŕ			deficient practice will not recur,				
	nurse and aides were getting one of the residents out of the room. LPN #9 indicated the other resident for Room 10 was just returning from the dining room and did not enter the room. LPN #9 indicated she phoned the Maintenance Director, then the Fire Department, and then the DNS. LPN #9 indicated she called the supervisors, because she wanted to be sure calling the Fire Department was the right thing to do.				i.e., what quality assurance			
					program will be put into			
					place? CQI Audit tool for			
					emergency fire drill protocol wi			
					be completed x4 monthly, then quarterly. Findings for CQI audit			
					will be processed monthly and action plan will be implemented			
					for any deficient practices belo			
					the 95% threshold Maintenance			
					Director/designee is responsib	-		
					to ensure compliance.			
					·			
	The facility policy for General Fire							
	Action Plan was provided by the							
Administrator from the facility's								
	Emergency Binder. The plan indicated,							
	"In case of fire - follow RACE procedure:							
	Alarm: Pull alarm - located at fire							
	exits							
	The Fire Department's run report was							
		conference room table on						
10/15/12 at 3:15 p.m. Review of the								
	10/13/12 at 3:13	p.iii. Keview of the	1					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155697		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 10/17/2012	
	PROVIDER OR SUPPLIEI	R AND SKILLED NURSING CENTE	517 N L	ADDRESS, CITY, STATE, ZIP CODE LITTLE LEAGUE BLVD (SVILLE, IN 47129	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	sounded on 9/26 Remarks indicat determined to be scorch burns with	the fire alarm was 5/12 at 5:07 p.m. ted, "The incident was e an excessive heat, th no ignition." is related to Complaint			

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